

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01999

## CERTIFICATE OF DEATH

01980

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. LENGTH OF STAY IN 1b <b>36</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b>		f. COUNTY <b>Montgomery</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		d. STREET ADDRESS <b>3119 Homewood Parkway</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>KOSMO</b>		First <b>J.</b>		Middle <b>AFFANASIEV</b>		Last <b>Nov. 1, 1897</b>		4. DATE OF DEATH <b>Feb. 10, 1962</b>		Month <b>Feb.</b>		Day <b>10</b>		Year <b>1962</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 1, 1897</b>		9. AGE (In years last birthday) <b>64</b>		IF UNDER 1 YEAR Months <b>3</b>		Days <b>9</b>		IF UNDER 24 HRS. Hours <b>3</b>		Min. <b>9</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Electrical</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>Naturalized</b>		13. FATHER'S NAME <b>Yakov Affanasiev</b>		14. MOTHER'S MAIDEN NAME <b>Xenia Sablin</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Wife</b> <b>Lydia W. Affanasiev</b>		Address <b>Same as Item 2.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Carcinoma with extensive liver metastases</b> <b>153.8</b> DUE TO <b>Primary Carcinoma of Colon</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>3 1/2 years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)																			
21. I certify that (I) (this hospital) attended the deceased from <b>January 2, 1962</b> to <b>Feb 10, 1962</b> that (I) (we) last saw the deceased alive on <b>Feb 10, 1962</b> , and that death occurred at <b>2:30 PM</b> , from the causes and on the date stated above.																			
22a. SIGNATURE <b>Charles F. Geschickter</b> 22b. PHYSICIAN'S NAME (Type) <b>Charles F. Geschickter</b> 22c. DATE SIGNED <b>Feb. 10, 1962</b> 22d. ADDRESS <b>1834 Conn. Ave., N.W., Washington, D.C.</b>																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b> 23b. DATE THEREOF <b>2-12-62</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b> 23d. LOCATION (City, town or county) (State) <b>Suitland, Maryland</b>																			
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY, Bethesda, Md.</b> 25a. REC'D BY REGISTRAR <b>FEB 14 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Wm. D. Evans</b>																			

(M)

01990

01990

Montgomery

Barryland

Montgomery

Kennington

Kennington

2119 Homewood Parkway

2119 Homewood Parkway

RODNO

J. ANANASIEV

Feb. 1, 1952

White

Nov. 1, 1952

02 5 2

Engineer

Electrical

Russia

Materialized

Yakov Alexandrov

Kennia Sablin

WOMAN

Lidia W. Alexandrov

came on from 2

*Very common in the area*  
*of the river*

*John F. ...*

Charles E. Genshler

1234 Conn. Ave. N.W.

Washington, D.C.

2-10-52

Robert Hill (operator)

Barryland

ROBERT A. PIERCE, Bethesda, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01981

02099

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>7 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sen. &amp; Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>DISTRICT OF COLUMBIA</u> <input checked="" type="checkbox"/> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> <u>47X-3</u> d. STREET ADDRESS <u>2 Pinehurst Circle N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Andrew</u> Middle <u>Julius</u> Last <u>Altman</u>		<b>4. DATE OF DEATH</b> Month <u>Feb.</u> Day <u>5</u> Year <u>1962</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>3-23-85</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Govt Employee</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Germany</u>	
<b>13. FATHER'S NAME</b> <u>Gustav Altman</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Dorothea Lipholtz</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no or unknown) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>Unknown</u>	
<b>17. INFORMANT</b> <u>Wife</u> <u>Sara Jane Altmann</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Valvular Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia and Kidney Shut down</u>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>1-29</u> e.m. <u>1962</u> p.m. <u>2-5</u>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>1-29</u> , 19 <u>62</u> to <u>2-5</u> , 19 <u>62</u> ; that (I) (we) last saw the deceased alive on <u>2-5</u> , 19 <u>62</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>Stuart L. Nelson</u>		<b>22b. DATE SIGNED</b> <u>2-5-62</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>STUART L. NELSON</u>		<b>22d. ADDRESS</b> <u>7600 Carroll Ave., Takoma Park, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>2-8-62</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Gate of Heaven Cem.</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Montgomery County, Md.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>ROBERT A. PUMPHREY</u>		<b>25a. REC'D BY REGISTRAR</b> <u>Bethesda, Md.</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Hines</u>		<b>25c. DATE</b> <u>FEB 9 1962</u>	

01981

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M

DISTRICT OF COLUMBIA

WASHINGTON

Attorney

2-1-52

Brotherly Love

John Lane Altmann

Same as item 5.

Unknown

STANLEY L. NELSON

2-5-52

ROBERT A. TEMPLE

Bellevue, Mo.

Case of Heaven Gem.

Montgomery County, Mo.

7-00 Carroll Ave., Tabor Park, Mo.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02001

## CERTIFICATE OF DEATH

01982

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <span style="float: right;"><b>MARYLAND</b></span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5721 Grosvenor Lane</b> <b>Resmor Sanitarium</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <b>--</b> b. COUNTY <b>--</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, DC</b> d. STREET ADDRESS <b>6674 32nd Street, N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>3. NAME OF DECEASED</b> (Type or print) <b>Ira S Barker</b>		<b>4. DATE OF DEATH</b> <b>Feb 17 1962</b>		<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>9/16/1875</b>		<b>9. AGE</b> (In years last birthday) <b>86</b> yrs. <b>IF UNDER 1 YEAR</b> Months <input type="checkbox"/> Days <input type="checkbox"/>		<b>IF UNDER 24 HRS.</b> Hours <input type="checkbox"/> Min. <input type="checkbox"/>					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired-- U.S. Government</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Delaware</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>U.S.A.</b>											
<b>13. FATHER'S NAME</b> <b>Joseph Q. Barker</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Sally Collison</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <b>no</b>				<b>17. INFORMANT</b> <b>Mrs. Betty B. Reed--</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA, TERMINAL</b> DUE TO (b) <b>ARTERIOSCLEROSIS, CEREBRAL</b> DUE TO (c) <b>ARTERIOSCLEROSIS GENERALIZED</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 Day</b> <b>10 YRS</b> <b>10 YRS</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)															
<b>20c. TIME OF INJURY</b> Hour a.m. <b>19</b> p.m.				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <b>JAN. 10, 1962</b> to <b>FEB. 17, 1962</b> , that (I) (we) last saw the deceased alive on <b>FEB. 17, 1962</b> , and that death occurred at <b>11 P.M.</b> , from the causes and on the date stated above.																			
<b>22a. SIGNATURE</b> <b>Robert G. Angle</b> M.D.												<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>				<b>22b. DATE SIGNED</b> <b>FEB 17, 1962</b>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Robert G. Angle</b>												<b>22d. ADDRESS</b> <b>5009 Del Ray Avenue</b> <b>Bethesda 14, Maryland</b>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>2/20/1962</b>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Cedar Hill Cemetery</b>				<b>23d. LOCATION</b> (City, town or county) (State) <b>Prince Georges County, Md.</b>							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>The S.H. Hines Co. - 2901 14th St., N.W.</b> <b>Washington 9, D.C.</b>												<b>25a. REC'D BY REGISTRAR</b> <b>DATE FEB 20 '62</b>				<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur E. Hines</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60

01382

02001

(M)

(I)

Montgomery

Business

Robert E. Anderson

1st

White

Male

Residence - U.S. Government

James H. Anderson

Mr. Robert E. Anderson  
6074 32nd Avenue, N.W.  
Atlanta, Ga.

Robert E. Anderson

2009 Del Ray Avenue  
Atlanta, Ga.

The S.A. Wilson Co. - 2201 11th St.  
Washington, D.C.  
2/20/1962  
Robert E. Anderson  
Atlanta, Ga.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

02002 **MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 01983

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>D.O.A.</u>				d. STREET ADDRESS <u>1523 E. Falkland Lane</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San &amp; Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Howard Calvin Barrett</u>				4. DATE OF DEATH Month Day Year <u>2 16 1962</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-18-93</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brick Layer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shomper-Wells Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Harrisonburg, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mr. Wm. H. Barrett</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Bear</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>W.W.I</u>				16. SOCIAL SECURITY NO. <u>577-16-9380</u>		17. INFORMANT <u>Mrs. Ethel Barrett (wife)</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of known heart disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Brochant</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Brochant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>2-16-62</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-19-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Prince George's Co. Maryland</u>	
23. FUNERAL DIRECTOR <u>Raymond A. Ziska</u> <u>Warner E. Pumphrey, Inc.</u>				24a. REC'D BY REGISTRAR <u>434 Georgia Ave.</u> <u>Silver Spring, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Pumphrey</u>	

MEDICAL CERTIFICATION

2220

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02003

## CERTIFICATE OF DEATH

01984

Item 9 Film G308 2/28/62 iwk

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>15 hours</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE <b>Maryland</b> f. COUNTY <b>St. Mary's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Indianhead</b> d. STREET ADDRESS <b>6 Clermont St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>James W. Bass</b>				4. DATE OF DEATH <b>Feb 20 1962</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/4/24</b>	
9. AGE (In years last birthday) <b>37 1/2 yrs.</b>		10. UNDER 1 YEAR Months <b>1</b> Days <b>18</b>		11. UNDER 24 HRS. Hours <b>18</b> Min. <b>00</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>J.C. Barrett</b>			
11. BIRTHPLACE (County & State, or foreign country) <b>North Carolina</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Walter Bass</b>				14. MOTHER'S MAIDEN NAME <b>Rochelle Coleman</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>				16. SOCIAL SECURITY NO. <b>105 2 Central</b>			
17. INFORMATION <b>Phyllis Bass / Jackson, Miss.</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4204</b> DUE TO <b>Acute myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Coronary-arteriosclerotic M.D.</b> DUE TO <b>27 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 1960</b> to <b>2/20/62</b> , that (I) (we) last saw the deceased alive on <b>2/19/62</b> , and that death occurred at <b>3:25 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Bernard J. Labish</b> M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <b>1800 Eye St. N.E. Wash. D.C.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-24-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lakewood Mem. Ph Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Jackson, Mississippi</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Paul Funeral Home</b>				25a. REC'D BY REGISTRAR <b>4812 G. Ave Wash. D.C.</b>			
25b. REGISTRAR'S SIGNATURE <b>Chas. E. Hanna</b>				25c. DATE <b>FEB 23 '62</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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*[Faint, mostly illegible handwritten text, possibly a letter or document, with some words like "James W. Bass" and "The National" visible.]*



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02004

## CERTIFICATE OF DEATH

01985

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.2em;">Montgomery</span> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="float: right;">c. LENGTH OF STAY IN lb</span> <span style="font-size: 1.2em;">Takoma Park</span> <span style="float: right;">1 day</span> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <span style="font-size: 1.2em;">Washington Sanitarium &amp; Hospital</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <span style="font-size: 1.2em;">Maryland</span> <span style="float: right;">b. COUNTY <span style="font-size: 1.2em;">Prince George's</span></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="float: right;">d. STREET ADDRESS</span> <span style="font-size: 1.2em;">Takoma Park</span> <span style="float: right;">1100 Linden Ave., Apt 101</span>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <span style="font-size: 1.2em;">Baumann</span>		<b>4. DATE OF DEATH</b> Month Day Year <span style="font-size: 1.2em;">February 3, 19 62</span>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>5. SEX</b> <span style="font-size: 1.2em;">male</span>	<b>6. COLOR OR RACE</b> <span style="font-size: 1.2em;">white</span>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">February 2, 1962</span>				
<b>9. AGE</b> (In years last birthday) yrs. <span style="font-size: 1.2em;">-</span> Months <span style="font-size: 1.2em;">0</span> Days <span style="font-size: 1.2em;">5</span> Hours <span style="font-size: 1.2em;">46</span>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">infant</span>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">none</span>			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <span style="font-size: 1.2em;">Montgomery, Maryland</span>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">America</span>		<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Charles Bruce Baumann</span>			
<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Virginia Mae Smith</span>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <span style="font-size: 1.2em;">no</span>		<b>16. SOCIAL SECURITY NO.</b> (If yes, give number and date of service)			
<b>17. INFORMANT</b> Address <span style="font-size: 1.2em;">mother-1100 Linden Ave., Apt 101, Takoma Park, Md.</span>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <span style="font-size: 1.5em;">Prenatality</span> 762.5 DUE TO <span style="font-size: 1.5em;">Pulmonary atelectasis</span> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <span style="font-size: 1.5em;">Pulmonary atelectasis</span> (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Hour a.m. <span style="font-size: 1.2em;">19</span> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">February 2, 1962</span> <b>to</b> <span style="font-size: 1.2em;">February 3, 1962</span> , <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.2em;">February 3, 1962</span> , <b>and that death occurred at</b> <span style="font-size: 1.2em;">6:20a</span> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <span style="font-size: 1.2em;">Winston E. Cochran</span> <span style="float: right;">M.D.</span>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <span style="float: right;">22b. DATE SIGNED</span> <span style="font-size: 1.2em;">2-3-62</span>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <span style="font-size: 1.2em;">Winston E. Cochran, M.D.</span>				<b>22d. ADDRESS</b> <span style="font-size: 1.2em;">800 Reservoir Dr. Silver Spring, Md.</span>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <span style="font-size: 1.2em;">Cremation</span>		<b>23b. DATE THEREOF</b> <span style="font-size: 1.2em;">2-5-62</span>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Washington Sanitarium and Hospital, Takoma Park, Md.</span>			
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <span style="font-size: 1.2em;">Robert A. Hare, M. D. Wash. San. &amp; Hospital</span>		<b>25a. REC'D BY REGISTRAR</b> <span style="font-size: 1.2em;">FEB 8 '62</span>		<b>25b. REGISTRAR'S SIGNATURE</b> <span style="font-size: 1.2em;">Arthur S. Hays</span>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)  
15M 9/60

Dr Broschart  
Contacted

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02005 CERTIFICATE OF DEATH 01986											
1. PLACE OF DEATH COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>1904 Amherst Dr.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Bernard Richard Bell</u>			4. DATE OF DEATH Month <u>2</u> Day <u>8</u> Year <u>1962</u>			5. SEX <u>m</u>			6. COLOR OR RACE <u>w</u>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>6-12-98</u>			9. AGE (In years last birthday) <u>63</u> yrs.			IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Newspaper</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>						13. FATHER'S NAME <u>Isaac Bell</u>			14. MOTHER'S MAIDEN NAME <u>Gertrude Rowe</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes Navy wwi</u>						16. SOCIAL SECURITY NO. <u>  </u>			17. INFORMANT Address <u>Mrs Elizabeth Bell - wife</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.0</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hr</u> <u>unknown</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. <u>  </u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1952</u> to <u>Feb 8</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>Feb 8</u> , 19 <u>62</u> , and that death occurred at <u>2:45 P</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>George Sharpe</u>						22b. DATE SIGNED			22c. PHYSICIAN'S NAME (Type) <u>George Sharpe</u>		
22d. ADDRESS <u>10511 Summit Ave Kensington, Md.</u>						22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>2/12/62</u>			23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEM</u>			23d. LOCATION (City, town or county) (State) <u>ARL VA</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.K. HUNTEMANN &amp; SON</u>						25a. REC'D BY REGISTRAR <u>DATE FEB 13 '62</u>			25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>		

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Mr. Hunter 21st Jan 1912

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02006  
CERTIFICATE OF DEATH  
01987

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>21 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Nebraska</b> b. COUNTY <b>Bertrand</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Route # 2</b> d. STREET ADDRESS <b>Route # 2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EVONNE</b> <b>JEAN</b> <b>BENSON</b>		4. DATE OF DEATH <b>February 20, 1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9 July 1956</b>
9. AGE (In years last birthday) <b>5 yrs.</b>		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>5</b> Hours <b>5</b> Min. <b>5</b>	11. IF UNDER 24 HRS. Months <b>5</b> Days <b>5</b> Hours <b>5</b> Min. <b>5</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None (Child)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Nebraska</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Charles L. Benson</b>	
14. MOTHER'S MAIDEN NAME <b>Betty Fritz</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subarachnoid hemorrhage</b> DUE TO (b) <b>Pseudomonas septicemia</b> DUE TO (c) <b>Acute lymphocytic leukemia</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>3 days</b> <b>18 months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <b>20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)</b> <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</b> <b>20f. (City or town) (County) (State)</b> <b>21. I certify that (a) (this hospital) attended the deceased from January 30, 1962, to February 20, 1962, that (b) (we) last saw the deceased alive on Feb. 20, 1962, and that death occurred at 12:40 p.m., from the causes and on the date stated above.</b> <b>22a. SIGNATURE</b> <b>Edward S. Henderson</b> M.D. <b>22b. DATE SIGNED</b> <b>February 21, 1962</b> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>Edward S. Henderson, M.D.</b> <b>22d. ADDRESS</b> <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/24/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>1400 Chapin St NW Washington DC</b>		23d. LOCATION (City, town or county) (State) <b>Bertrand Nebraska</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co.</b>		25a. REC'D BY REGISTRAR <b>FEB 23 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		25c. DATE <b>FEB 23 '62</b>	



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The Clinical Center

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Bedford

Charles J. Benson

Betty White

None

No

The Clinical Center, Bedford, Mass.  
The Medical Record

Feb. 20, 42

January 30, 42

February 20, 42

Institutes of Health, Bedford, Mass.  
The Clinical Center, Bedford, Mass.

Bedford, Mass.

Bedford, Mass.



MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

02007

CERTIFICATE OF DEATH

01989

Item 6 Film G307 2/15/62 iwk

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>				c. LENGTH OF STAY IN 1b <u>5mo.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wheaton Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Sadie</u> Middle <u>Bernstein</u> Last <u>Bernstein</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>4</u> Year <u>1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/6/75</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>86</u> Days <u>86</u> Hours <u>86</u> Min.		IF UNDER 24 HRS. Months <u>86</u> Days <u>86</u> Hours <u>86</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>Russia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Abraham Goldberg</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Rubin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Mrs. Edna Schwartz</u> Address <u>5162, 34th St. N.W., Wash. D.C.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> (b) <u>Carcinoma of the Breast</u> (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>170X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive and Arteriosclerotic Vascular Disease</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>19</u>							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>JULY 3</u> 19 <u>62</u> to <u>FEB 4</u> 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>FEB 3</u> 19 <u>62</u> , and that death occurred at <u>9:05</u> PM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert L. Krichmar</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> FEB 4 1962							
22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) <u>ROBERT L. KRICHMAR</u>							
22d. ADDRESS <u>7733 ALASKA AVENUE NW WASH DC</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>							
23b. DATE THEREOF <u>2-6-62</u>							
23c. NAME OF CEMETERY OR CREMATORY <u>ONEV SHOLOM-TALMUD TORAH CEM. WASHINGTON DC.</u>							
23d. LOCATION (City, town, or county) (State)							
24. FUNERAL DIRECTOR'S SIGNATURE <u>BERNARD DANZANSKY</u> ADDRESS <u>1506 - 3501-14th St NW</u>							
25a. REC'D BY REGISTRAR DATE <u>FEB 8 '62</u>							
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Krasner</u>							

MEDICAL CERTIFICATION

1880

1880

(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02008

## CERTIFICATE OF DEATH

01990

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 TAKOMA PARK MD.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6807 ALLEGHENY ST.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Betz</u> Last <u>Betz</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>17</u> Year <u>1962</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>UNKNOWN</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>WILLIAM BETZ</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE BETZ</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>JOSEPH LAPIANA JR. ATTY. WASHINGTON, D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive heart failure</u> DUE TO (c) <u>arteriosclerosis &amp; senility</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3-5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. 1.</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Feb-17, 1962</u> to <u>Feb-17, 1962</u> , that I last saw the deceased alive on <u>Feb-17, 1962</u> , and that death occurred at <u>8:20 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sydney Leventhal</u>				ADDRESS (Street, city or town, state) <u>9210 Colesville Rd, Bethesda, Md.</u>			
PHYSICIAN'S NAME (Type) <u>—</u>				DATE SIGNED <u>2/17/62</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>21 FEB 1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ASBEY MAUSOLEUM</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>RINALDI FUNERAL HOME</u>				ADDRESS <u>7400 GEORGIA AVE NW</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>FEB 20 '62</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Finna</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02009

## CERTIFICATE OF DEATH

Item 9 Film G307 2/25/62 iwk

01991

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN lb		d. STREET ADDRESS <u>5526 Oakmont Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kensington Gardens Sanitorium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARTHA</u> Middle <u>N.</u> Last <u>BLANKENSHIP</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>18</u> Year <u>1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>27 Dec. 1875</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Camden Co. Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William A. Ayers</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Hamilton Dougherty</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Daughter</u>		Address <u>Mrs. Beulah Lacey</u> Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CIRCULATORY COLLAPSE</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>ARTERIO SCLEROTIC HEART DISEASE</u> DUE TO (c) <u>GEN'L ARTERIO SCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2+ HRS.</u> <u>5+ YRS.</u> <u>10+ YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PNEUMONIA &amp; UREMIA</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>D. N. A.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/17</u> , 19 <u>62</u> , to <u>2/18</u> , 19 <u>62</u> ; that (I) (we) last saw the deceased alive on <u>2/16</u> , 19 <u>62</u> , and that death occurred at <u>2:40</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Charles J. Savarose Jr.</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>2/18/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>CHARLES J. SAVAROSE JR.</u>		22d. ADDRESS <u>4890 BATTERY LANE BETHESDA,</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit</u>		23b. DATE THEREOF <u>2-19-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Wichita Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Wichita, Kansas</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>		ADDRESS <u>Bethesda, Md.</u>	
25a. REC'D BY REGISTRAR <u>FEB 21 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

(M)

12002

01931

5225 Oakmont Ave.

Bedford

Maryland

Montgomery

No

None

Mrs. Boufah Jacey

Shore as item 2.

Exhibit-Transit 1-10-62

Whitman Park Cemetery, Wichita,

Kansas

ROBERT A. FLEMING

Bedford, Md.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02010

## CERTIFICATE OF DEATH

01992

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Ohio</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN lb <b>9 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda Md.</b>		d. STREET ADDRESS <b>223 North Wood Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Emil</b> Middle <b>Ignatius</b> Last <b>Bodenlos</b>		4. DATE OF DEATH Month <b>February</b> Day <b>8</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6 April 1900</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Army</b>		9b. AGE (In years last birthday) <b>61 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Army</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>BODENLOS, Robert I.</b>		14. MOTHER'S MAIDEN NAME <b>GEDEON, Charlotte</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WW II</b>		17. INFORMANT Address <b>wife Mrs. Marie Al Bodenlos Same as #2</b>	
16. SOCIAL SECURITY NO.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Failure</b> DUE TO <b>Rheumatic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>4-1-62</b> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>31 January....., 1962, to 8 February....., 1962</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>8 February.....1962</b> , and that death occurred at <b>2230 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>W.F. Warrender</b> M.D.		22b. DATE SIGNED <b>9 Feb 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>W.F. WARRENDER LT MC USN</b>		22d. ADDRESS <b>U.S. NAVAL HOSPITAL BETHESDA, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-13-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Arlington Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. PUMPHREY</b>		25a. REC'D BY REGISTRAR <b>FEB 13 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Robert A. PUMPHREY</b>		25c. REGISTRAR'S SIGNATURE <b>Robert A. PUMPHREY</b>	

01993

01993

M

CHIEF

WILLIAM

RECEIVED

9 days

RECEIVED (1911)

353 North Wood Street

U.S. Naval Hospital, Bethesda Md.

RECEIVED

RECEIVED

RECEIVED

April 1900

RECEIVED

RECEIVED

Ohio

U.S. Army

U.S. Army, Chicago

RECEIVED, Robert I.

RECEIVED

RECEIVED

also see. Reels in Reels 22 and 23

January 1900

January 1900

RECEIVED

U.S. Naval Hospital, Bethesda Md.

RECEIVED

Washington National Cemetery Arlington Virginia

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02011

## CERTIFICATE OF DEATH

01993

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>42 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Halltown</b>		85x.3	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>No street address</b>			
3. NAME OF DECEASED (Type or print) <b>William</b>		First <b>Elwood</b> Middle <b>Bowers</b> Last		4. DATE OF DEATH Month <b>February</b> Day <b>27</b> Year <b>19 62</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 14, 1925</b>	9. AGE (In years last birthday) <b>36</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Postmaster</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>		11. BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Winerd Bowers</b>				14. MOTHER'S MAIDEN NAME <b>Freda McAboy</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>234-38-7576</b>		17. INFORMANT Address <b>The Medical Records The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cardiac failure</b> <b>204.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Acute myelogenous leukemia</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>7 months</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (if) (this hospital) attended the deceased from <b>January 16, 1962</b> to <b>February 27, 1962</b> that (I) (we) last saw the deceased alive on <b>February 27, 1962</b> , and that death occurred at <b>7:50 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Robert H. Levin</b>		M.D.	ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>2/28/62</b>			
22c. PHYSICIAN'S NAME (Type) <b>Robert H. Levin, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3/2/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Edge Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Charles Town, West Va.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Donald Eckles</b>		ADDRESS <b>Harpers Ferry, West Va.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 6 '62</b>	25b. REGISTRAR'S SIGNATURE <b>Clara S. Kinsler</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

01903

01903

M

West Virginia

Marshall

12 days

Marshall

He also is a member

The Marshall County, West Virginia, U.S.

June 11, 1902

West Virginia

Government

Postmaster

Marshall County

521-5-755 The Marshall County, West Virginia, U.S.

Mar 11

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02012					01994				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY		Montgomery			a. STATE		Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Bethesda			b. COUNTY		Montgomery		
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Kensington		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Suburban Hospital			d. STREET ADDRESS		10304 Montgomery Ave.		
e. IS RESIDENCE ON A FARM?					e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH		5. SEX		
First Middle Last					Month Day Year		Female		
NINA HOOD BRAZELTON					Feb. 26, 1962				
6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
White				Sept. 15, 1882		79 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Housewife				Alabama		U. S.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
William Hood				Valinte Yielding					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		None		Son		Same as Item 2.			
Irving H. Brazelton									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:								3 MONTHS	
IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma to Lung</i>									
DUE TO (b) <i>Primary Carcinoma of Uterus</i>								3 YRS	
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
19									
21. I certify that (I) (this hospital) attended the deceased from Jan 1952 to Feb 1962 that (I) (we) last saw the deceased alive on Feb 26 1962 and that death occurred at 3:30 P.M. from the causes and on the date stated above.									
22a. SIGNATURE				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)			
<i>Leo I. Donovan M.D.</i>				2/27/62		AEO I DONOVAN M.D.			
22d. ADDRESS				22e. REC'D BY REGISTRAR		22f. REGISTRAR'S SIGNATURE			
8218 Wisconsin Ave., Bethesda, Md.				DATE MAR 1 '62		<i>Arthur S. Kraus</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial		2-28-62		Arlington Natl Cem.		Arlington, Virginia.			
24. FUNERAL DIRECTOR'S SIGNATURE				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
ROBERT A. PUMPHREY				DATE MAR 1 '62		<i>Arthur S. Kraus</i>			
Bethesda, Md.									

(M)

2012

0199

Montgomery  
Bellevue  
Shubert Hospital  
2020 Montgomery Ave.  
Kenaston  
Montgomery

Female White  
Housville  
William Hood  
None  
Twinn H. Dinkelson  
Valerie Yelaine  
Alabama  
Dec. 18, 1982  
BRANTON  
Feb. 20, 1983  
H. 2.

Same as Item 2.

Robert A. Panshrey  
-38-12  
Arlington Hall Cem.  
Arlington, Virginia  
Bellevue, Md.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02013

## CERTIFICATE OF DEATH

01995

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN lb <u>15 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Marilea Nursing Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Chevy Chase</u> d. STREET ADDRESS <u>1 6420 Western Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Alice</u> <u>Chase</u> <u>Briggs</u>			<b>4. DATE OF DEATH</b> <u>Feb. 13</u> <u>1962</u>				
<b>5. SEX</b> <u>female</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Sept. 20, 1875</u>	<b>9. AGE</b> (In years last birthday) <u>86</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own g home</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Toledo, Ohio</u>			
<b>13. FATHER'S NAME</b> <u>Herman Walbridge</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Elizabeth Walbridge</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or defense service)		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> <u>Southwick W. Briggs</u> <u>6420 Western Ave. Chase, Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> 500X DUE TO (b) <u>bronchial pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>chronic bronchitis</u>					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>4 days</u> <u>1 day</u> <u>2 1/4 days</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e): <u>None</u>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)				
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b>	<b>(County)</b>	<b>(State)</b>		
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Sept 15, 1959</u> <b>to</b> <u>Feb 13, 1962</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Feb 12, 1962</u> <b>and that death occurred at</b> <u>11:00 P</u> <b>M, from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>John S. Rogers</u>			<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> <u>1919 Seminary Rd., Silver Spring, Maryland</u>		<b>22b. DATE SIGNED</b> <u>Feb 13, 1962</u>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>2-16-62</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Rock Creek Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Washington, D.C.</u>		
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <u>Warner E. Pumphrey, Inc.</u>			<b>25a. REC'D BY REGISTRAR</b> <u>Raymond A. Gjesa</u> <u>843d</u> <u>Georgia Ave.</u> <u>Silver Spring, Md.</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hanna</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60

01995

01995



*Handwritten text, mostly illegible due to blurring and bleed-through. Some words like "Project" and "Report" are faintly visible.*

*Handwritten text at the bottom of the page, including what appears to be a signature and some notes. The text is very faint and difficult to decipher.*

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02014

## CERTIFICATE OF DEATH

01996

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN 1b <u>10 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SUBURBAN HOSPITAL</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <u>D.C.</u> <span style="float: right;">b. COUNTY <u>47X-3</u> ✓</span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> <span style="float: right;">D.C.</span> d. STREET ADDRESS <u>4341-CHESAPEAKE ST. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>PATRICK J. BRODERICK</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>Feb. 6, 1962</u> Month Day Year					
<b>5. SEX</b> <u>MALE</u>		<b>6. COLOR OR RACE</b> <u>WHITE</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>APRIL 25<sup>TH</sup> 1882</u> 79 yrs.		<b>9. AGE</b> (In years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>D.C. GOVERNMENT</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>IRELAND</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>MICHAEL BRODERICK</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>SULIA DOODY</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>579-46-0969</u>		<b>17. INFORMANT</b> <u>SULIA BRODERICK</u> Address <u>2 D.</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Branch pneumonia</u> DUE TO (b) <u>Cerebral thrombosis with infarct of pons</u> DUE TO (c) <u>Cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>  <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> _____ (County) _____ (State) _____			
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>Jan 27, 1962</u> to <u>present</u> , that (I) (we) last saw the deceased alive on <u>Feb 6, 1962</u> , and the death occurred at <u>12 noon</u> , from the causes and on the date stated above.									
<b>22a. SIGNATURE</b> <u>C P Ryland</u>				<b>22b. DATE SIGNED</b> <u>2-7-62</u>					
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>C P RYLAND</u>				<b>22d. ADDRESS</b> <u>4400-49 ST NW Washington 16 DC</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>2/9/62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>GATE OF HEAVEN</u>		<b>23d. LOCATION</b> (City, town or county) <u>WHEATON</u> (State) <u>MD.</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Timothy Naulon</u> ADDRESS <u>4748 Wisc. AVE.</u>				<b>25a. REC'D BY REGISTRAR</b> DATE <u>FEB 13 '62</u>		<b>25b. REGISTRAR'S SIGNATURE</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



*[Faint handwritten notes at the bottom of the page]*

**FOR STATE  
HEALTH DEPT.**

**DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME  
5M 9/60

1. <b>PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakoma Park</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium</u>		2. <b>USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u> d. STREET ADDRESS <u>2115 Rolander ST</u>	
3. <b>NAME OF DECEASED</b> (Type or print) <u>Hubert Lawrence Brown</u> First Middle Last		4. <b>DATE OF DEATH</b> <u>2 6 1962</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-15-08</u>
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>of Hardware</u>	
11. BIRTHPLACE (State or foreign country) <u>S. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Thomas P. Brown</u>		14. MOTHER'S MAIDEN NAME <u>Anna Meyers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-05-8610</u>	
17. INFORMANT <u>Lynne Brown</u>		Address <u>Same</u> Address <u>Daughter</u>	
18. <b>CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work et work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCART</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>2-6-62</u>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
22a. <b>DATE OF CREMATION</b> <u>2/6/62</u>	22b. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>	22c. LOCATION (City, town, or country) (State) <u>Pr. Geo. Co., Maryland</u>	
23. FUNERAL DIRECTOR <u>The S.H. Hines Co., 2901 14th St. N.W., Wash, D.C.</u>		24a. REC'D BY REGISTRAR <u>FEB 7 '62</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

01007

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02016

## CERTIFICATE OF DEATH

01998

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>(Woodside Park) Silver Spring</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>(Woodside Park) Silver Spring</b>			
c. LENGTH OF STAY in 1b <b>7 years.</b>				d. STREET ADDRESS <b>9008 Fairview Road</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>9008 Fairview Road</b>				e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Ethel Rosetta Burdine</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>February 5, 1962</b>			
<b>5. SEX</b> <b>female</b>		<b>6. COLOR OR RACE</b> <b>white</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>11/21/1906</b>	
<b>9. AGE</b> (In years last birthday) <b>55 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>At Home</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Washington, D.C.</b>	
<b>13. FATHER'S NAME</b> <b>Alfred H. Burdine</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>				<b>16. SOCIAL SECURITY NO.</b> <b>no</b>		<b>17. INFORMANT</b> Address <b>James P. Casbarian-9008 Fairview Road Silver Spring, Maryland</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> 44-3X DUE TO (b) <b>Hypertensive Heart Disease</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) <b>Pneumonia</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 hr 10 yrs 1 wk</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chert Deformity from Polio</b>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>080.3</b>			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from 1945, 19 to Feb 5, 1962 that (I) (we) last saw the deceased alive on Feb 4, 1962, and that death occurred at 3A.M. from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>Harold Heiges</b> M.D.				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>2/5/62</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Harold Heiges</b>				<b>22d. ADDRESS</b> <b>1835 Eye St NW DC</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>2/8/62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Glenwood Cemetery</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Washington, D.C.</b>	
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <b>The S.H. Hines Company</b>				<b>25. REC'D BY REGISTRAR</b> <b>DATE FEB 7 '62</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>William L. Hines</b>	

(M)

02016

01938

Longmont, CO

Longmont, CO

(Woodbine Park) Spring

(Woodbine Park) Silver Spring

9008 Highway Road

9008 Highway Road

Eden

Eden

Female white

11/21/200

At Home

Washington, D.C.

Alfred H. Burdick

Mary E. Davis

no

no

9008 Highway Road

James F. Campbell - Silver Spring, Maryland

5/5/02

5/5/02

Washington, D.C.

The E. W. Hines Company  
Washington, D.C.

5001 13th St. N.E.  
Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02017

01999

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>21 Silver Spring</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>10410 Lorain Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Sanitorium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MAIE</u>	First Middle Last	4. DATE OF DEATH <u>BURNS</u>	Month <u>2</u> Day <u>10</u> Year <u>1962</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>28 Mar. 1865</u> 96 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Chas Co., W. Va.</u>	
13. FATHER'S NAME <u>Dennis Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		17. INFORMANT <u>Glenn C. Dorsey</u> Address <u>10410 Lorain Ave., Sil. Sp. Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary Accburn</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chr Wegner's disease &amp; Lung cancer</u> DUE TO <u>Acute Broncho pneumonia</u> 1/29/62 to 2/7/62.		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>17 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
2Dc. TIME OF INJURY Month, Day, Year. Hour a.m. p.m. <u>9/11/1938</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office, shop, etc.) <u>2101</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>2/7/62</u> to <u>2/10/62</u> , that (I) (we) last saw the deceased alive on <u>2/7/62</u> , and that death occurred at <u>3:35 AM</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Howard T Morse</u> M.D. 22b. DATE SIGNED <u>2/10/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Howard T Morse</u>		22d. ADDRESS <u>7030 Carroll Ave Takoma Park Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-12-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Frederick, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>DEAL FUNERAL HOME</u> ADDRESS <u>4812 Ga. Ave., N.W., Wash, DC</u>		25a. REC'D BY REGISTRAR <u>FEB 14 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

01999

01030

M



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02018

## CERTIFICATE OF DEATH

02000

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>1 week</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Dist. of Co.</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u> d. STREET ADDRESS <u>3636-16th St. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Annie</u> First <u>FURMAN</u> Middle <u>Byerly</u> Last		<b>4. DATE OF DEATH</b> <u>Feb.</u> <u>15</u> <u>1962</u>		<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>white</u>			
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>10/18/78</u>		<b>9. AGE</b> (In years last birthday) <u>83</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Home maker</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>own home</u>			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Pennsylvania</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>		<b>13. FATHER'S NAME</b> <u>Nathan I. Furman</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>unknown? Walls mitch</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> <b>16. SOCIAL SECURITY NO.</b> <u>None</u> <b>17. INFORMANT</b> <u>H. Scott Byerly</u> <u>6407-31st N.W. Washington, D.C.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> 260X DUE TO (b) <u>arteriosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Diabetic mellitus</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 years</u> INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. <u>  </u> p.m. <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>vacation</u> <b>20f. (City or town)</b> <u>Del.</u> <b>(County)</b> <u>Present</u> <b>(State)</b> <u>  </u>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>December 1961</u> <b>to</b> <u>Present</u> <b>that (I) (we) last saw the deceased alive on</b> <u>2/15/62</u> <b>and that death occurred at</b> <u>4:45 PM</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Donald Ekman</u> <b>22b. DATE SIGNED</b> <u>2-15-62</u>		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>					
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Donald Ekman</u>		<b>22d. ADDRESS</b> <u>5707 Wisconsin Ave., Chevy Chase, Maryland</u>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>2-19-62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Pomfret Manor Cemetery</u>			
<b>23d. LOCATION (City, town or county)</b> <u>Northumberland Co.</u> <b>(State)</b> <u>Pennsylvania</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Warren E. Humphrey</u> <u>8434 Georgia Ave SE, Md.</u>					
<b>25a. REC'D BY REGISTRAR</b> <u>FEB 19 1962</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles E. Kraus</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



05009

02013

(M)

2707 Wisconsin Ave., Chevy Chase, Maryland

Donald E. Brown

Northwestern Land Co.

1-1-52

11-1-52



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02019

## CERTIFICATE OF DEATH

02001

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont Co.</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>37 Wheaton</u>			
c. LENGTH OF STAY IN 1b <u>3 days</u>				d. STREET ADDRESS <u>12039 Valleywood Drive</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Carl Jerome</u> <u>Bylsma</u>				4. DATE OF DEATH Month Day Year <u>Feb.</u> <u>28</u> <u>1962</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Month Day Year <u>Feb. 25, 1962</u>	
9. AGE (In years last birthday) <u>2</u>		IF UNDER 1 YEAR Months Days Hours Min <u>0</u> <u>00</u> <u>00</u> <u>00</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Roger B. Bylsma</u>				14. MOTHER'S MAIDEN NAME <u>Emma L. Cahoon</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>Mother's chart</u>			
17. INFORMANT Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PREMATURITY</u>							
DUE TO (b) <u>&gt; 76X</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
MEDICAL CERTIFICATION							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/25</u> , 19 <u>62</u> , to <u>2/28</u> , 19 <u>62</u> ; that (I) (we) last saw the deceased alive on <u>2-28</u> , 19 <u>62</u> , and that death occurred at <u>8 P.</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Dr. W. Pearlman</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-28-62</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <u>4700 Brady Blvd., Chevy Chase, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-3-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		23d. LOCATION (City, town or county) (State) <u>Montgomery County, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. Don DeVol</u>				ADDRESS <u>2224 Wise Ave. N.W.</u>		25. REC'D BY REGISTRAR DATE <u>6 '62</u>	
25. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>							

-2274285152

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

The first of the series of  
 experiments was made on  
 the 1st of March 1881  
 and was a failure. The  
 second was made on the  
 2nd of March 1881 and  
 was a success. The third  
 was made on the 3rd of  
 March 1881 and was a  
 success. The fourth was  
 made on the 4th of March  
 1881 and was a success.  
 The fifth was made on the  
 5th of March 1881 and  
 was a success. The sixth  
 was made on the 6th of  
 March 1881 and was a  
 success. The seventh was  
 made on the 7th of March  
 1881 and was a success.  
 The eighth was made on  
 the 8th of March 1881  
 and was a success. The  
 ninth was made on the  
 9th of March 1881 and  
 was a success. The tenth  
 was made on the 10th of  
 March 1881 and was a  
 success. The eleventh was  
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 1881 and was a success.  
 The twelfth was made on  
 the 12th of March 1881  
 and was a success. The  
 thirteenth was made on  
 the 13th of March 1881  
 and was a success. The  
 fourteenth was made on  
 the 14th of March 1881  
 and was a success. The  
 fifteenth was made on  
 the 15th of March 1881  
 and was a success. The  
 sixteenth was made on  
 the 16th of March 1881  
 and was a success. The  
 seventeenth was made on  
 the 17th of March 1881  
 and was a success. The  
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 the 18th of March 1881  
 and was a success. The  
 nineteenth was made on  
 the 19th of March 1881  
 and was a success. The  
 twentieth was made on  
 the 20th of March 1881  
 and was a success. The  
 twenty-first was made on  
 the 21st of March 1881  
 and was a success. The  
 twenty-second was made  
 on the 22nd of March 1881  
 and was a success. The  
 twenty-third was made  
 on the 23rd of March 1881  
 and was a success. The  
 twenty-fourth was made  
 on the 24th of March 1881  
 and was a success. The  
 twenty-fifth was made  
 on the 25th of March 1881  
 and was a success. The  
 twenty-sixth was made  
 on the 26th of March 1881  
 and was a success. The  
 twenty-seventh was made  
 on the 27th of March 1881  
 and was a success. The  
 twenty-eighth was made  
 on the 28th of March 1881  
 and was a success. The  
 twenty-ninth was made  
 on the 29th of March 1881  
 and was a success. The  
 thirtieth was made on  
 the 30th of March 1881  
 and was a success.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02020					02002				
Item 9 Film 0307 2/26/62 iwk									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase Village</u> c. LENGTH OF STAY in 1b <u>13 Wks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>#8 W LenoX St</u>					2. USUAL RESIDENCE (Where deceased lived, if Institution-Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase Village</u> d. STREET ADDRESS <u>#8 W LenoX St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Katherine Agnes Byrne</u>					4. DATE OF DEATH <u>Feb 20 1962</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 25 1875</u>		9. AGE (In years last birthday) <u>86 8/17</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Jersey City N.J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME <u>DOHRICK BYRNE</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Hickey</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>GRACET CAULFIELD * #8 W LENOX ST</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4 SIX</u> DUE TO <u>Ruptured Abdominal Aortic Aneurysm</u> Conditions, if any, which gave rise to immediate cause (b) <u>Arterio Sclerosis</u> (e), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Osteo-Arthritis.</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 15</u> , 1962 to <u>Feb 20</u> , 1962 that (I) (we) last saw the deceased alive on <u>Feb 20</u> , 1962 and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.					22a. SIGNATURE <u>Philip A. Caulfield</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>Feb 20 1962</u>				
22c. PHYSICIAN'S NAME (Type) <u>Philip A. Caulfield</u>					22d. ADDRESS <u>2701 Conn. Ave. N.W. Wash D.C.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-22-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Rockville Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>H. Don Welbel</u> ADDRESS <u>2224 Wis Ave. N.W. D.C.</u>					25a. REC'D BY REGISTRAR <u>FEB 23 '62</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>		

SEKISO

05050

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## CERTIFICATE OF DEATH

Reg. Dist. No. 02003

02021

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVY CHASE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 CHEVY CHASE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7302 POMANDER LANE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MICHAEL P. CALLAGHAN</b>		4. DATE OF DEATH Month Day Year <b>2-28-1962</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-4-67</b>
9. AGE (In years last birthday) <b>94</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED CONTRACTOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CHEVY CHASE, D.C.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>JOHN O'CALLAGHAN</b>		14. MOTHER'S MAIDEN NAME <b>HONORA DUNSTON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>MRS. PATRICK J. Mc CARTHY (SAME AS #1)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CEREBRAL ARTERIOSCLEROSIS</b> DUE TO (c) <b>GENERALIZED ARTERIOSCLEROSIS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>GOUTY ARTHRITIS</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b> <b>7 years</b> <b>7 years</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>SEPT. 1954</b> to <b>FEB. 28, 1962</b> that I last saw the deceased alive on <b>FEB. 27, 1962</b> , and that death occurred at <b>9:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. Blaine Fitzgerald</b>		ADDRESS (Street, city or town, state) <b>8218 WISCONSIN AVE. BETHESDA, MD.</b>	
PHYSICIAN'S NAME (Type) <b>BETHESDA, MD.</b>		DATE SIGNED <b>2-28-62</b>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-3-62</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Forest Glen, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis Collins</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 5 '62</b>	
ADDRESS <b>3821-14th St. N.W.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove each of the papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02022					02004				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			a. STATE		b. COUNTY		
Montgomery		Bethesda			Maryland		Montgomery		
c. LENGTH OF STAY IN 1b		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		
48 days		The Clinical Center, Bethesda 14, Md.			17 Takoma Park		7711 Greenwood Avenue		
3. NAME OF DECEASED (Type or print)					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
First Middle Last					4. DATE OF DEATH Month Day Year				
Clarence Reese Campbell					February 19 19 62				
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Male		White				October 1, 1941		20 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Roofing		Roofing		Virginia		Months Days		Hours Min.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?					
Clarence Everett Campbell		Lottie B. Cash		U.S.A.					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT The Medical Record					
No		224-48-254		The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Insufficiency								3 days	
DUE TO (b) Undifferentiated tumor primary in Prostate gland									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) with Pulmonary Metastases								1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19									
21. I certify that (A) (this hospital) attended the deceased from January 2, 1962, to February 19, 1962, that (I) (we) last saw the deceased alive on February 19, 1962, and that death occurred at 12:15 p.m. from the causes and on the date stated above.									
22a. SIGNATURE Michael Field M.D.					22b. DATE SIGNED February 20, 1962				
22c. PHYSICIAN'S NAME (Type) Michael Field M.D.					22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial		2/24/62		Stonewall Mems. Gardens Manassas Va.					
24. FUNERAL DIRECTOR'S SIGNATURE W W Chambers Co. Washington DC					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		
					DATE FEB 23 '62				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02023 CERTIFICATE OF DEATH 02005											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>						c. LENGTH OF STAY IN hr. <b>26½ hrs.</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban</b>						X <b>Bethesda</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						185 Seven Lock Road					
3. NAME OF DECEASED (Type or print) First <b>Virginia</b> Middle <b>Claggett</b> Last <b>Claggett</b>						4. DATE OF DEATH Month <b>February</b> Day <b>18</b> Year <b>1962</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 22, 1909</b>		9. AGE (In years last birthday) <b>52 yrs.</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>18</b> Hours <b>18</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Howard</b>						14. MOTHER'S MAIDEN NAME <b>Elizabeth ?</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)						16. SOCIAL SECURITY NO.					
17. INFORMANT <b>Ernest Claggett (son) 185 Seven Lock Rd.</b>						Address <b>Bethesda, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>auricular fibrillation</b> Conditions, if any, which gave rise to immediate cause (b) <b>arteriosclerotic heart disease</b> (c) <b>12 yrs.</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Washington, D.C.</b>		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-12-62</b> to <b>2-18-62</b> , that (I) (we) last saw the deceased alive on <b>2-17-62</b> , and that death occurred at <b>1:00 P.M.</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Dorothy Hill,</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2-18-62</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dorothy Hill</b>						22d. ADDRESS <b>Rockville, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL: (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/21/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial,</b>		23d. LOCATION (City, town or county) (State) <b>Washington, D.C.</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden.</b>						ADDRESS <b>Rockville, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 21 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur J. Hume</b>	

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Lincoln, Nebraska, U.S.A.

Lincoln, Nebraska, U.S.A.

Robert A. Lincoln

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02024

02006

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN lb <u>8 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <u>D. C.</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>1316 T Street SE, Apt. #1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>Arthur (n) Clemons</u>		<b>4. DATE OF DEATH</b> Month <u>February</u> Day <u>18</u> Year <u>1962</u>		<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Caucasian</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>November 19, 1899</u>		<b>9. AGE</b> (In years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Naval Officer</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>New York</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>							
<b>13. FATHER'S NAME</b> <u>Fred Clemons</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Hattie Denure</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW I WW II</u> <b>16. SOCIAL SECURITY NO.</b>				<b>17. INFORMANT</b> Address <u>Wife: Mrs. Pauline Clemons, Same as #2</u>							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma Right Colon with Metastases</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>153.8</u> (e), stating the underlying cause last. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Feb. 11, 1962</u> , to <u>Feb. 18, 1962</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Feb. 18, 1962</u> , and that death occurred <u>2:13 PM</u> from the causes and on the date stated above.											
<b>22a. SIGNATURE</b> <u>M. C. Jorgensen</u> M.D.				<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>February 19, 1962</u>					
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>M. C. JORGENSEN LT MC USN</u>				<b>22d. ADDRESS</b> <u>U. S. Naval Hospital, Bethesda, Maryland</u>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>2-21-62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Arlington, Virginia</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Francis Gasch &amp; Sons</u> ADDRESS <u>Hyattsville, Md.</u>				<b>25a. REC'D BY REGISTRAR</b> DATE <u>FEB 21 '62</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kane</u>					

05008

05008

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Person (No. 1)

U. S. Naval Hospital

(a)

Canadian

British Naval Officer

First Officer

W. E. M. II

Yes

Ammonia (light color with nitrogen)

X

Nov. 18, 1942

Feb. 11, 1943

Nov. 13, 1942

M. C. Thompson Jr. & Son

Wilmington, Delaware

Wilmington, Delaware



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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
02025					02007					
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Alaska</b> b. COUNTY <input checked="" type="checkbox"/>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Noorvik</b> <b>88 X .3</b>			d. STREET ADDRESS <b>( No street address )</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>George</b> Last <b>Coffin</b>					4. DATE OF DEATH Month <b>February</b> Day <b>7</b> Year <b>19 62</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Yellow</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 12, 1959</b>		9. AGE (In years last birthday) <b>2</b> yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Alaska</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Edward Coffin</b>					14. MOTHER'S MAIDEN NAME <b>Mary Lou ( Unknown )</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give year or dates of service)			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Records</b> <b>The Clinical Center, Bethesda 14, Maryland</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> 2890 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pneumonia</b> (c) <b>Hand Shuller Christian Disease</b>								INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b> <b>1 day</b> <b>2 1/2 years</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <b>e.m.</b> <b>19</b> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 23, 1960</b> to <b>February 7, 1962</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>February 7, 1962</b> , and that death occurred at <b>8:15 PM</b> from the causes and on the date stated above.										
22a. SIGNATURE <b>Geo. H. Porter III</b> M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <b>2/10/62</b>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>George H. Porter, III, M.D.</b>					22d. ADDRESS <b>The Clinical Center, National Institutes Of Health, Bethesda 14, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-13-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Washington National</b>		23d. LOCATION (City, town or county) (State) <b>Suitland Maryland</b>				
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers</b>					ADDRESS <b>6-8655- Ga. Ave. S. S. Md.</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 13 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

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June 22, 1961, Saturday, 1961

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02026 CERTIFICATE OF DEATH 02008											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN lb <b>15 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				d. STREET ADDRESS <b>6416 Marjory Lane</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Rose (None) Cohen</b>						4. DATE OF DEATH <b>February 27, 19 62</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 21, 1903</b>		9. AGE (In years last birthday) <b>58 yrs.</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bookkeeper</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Office</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob Wolf</b>						14. MOTHER'S MAIDEN NAME <b>Jennie Green</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>102-01-4109</b>		17. INFORMANT <b>The Medical Records</b> <b>The Clinical Center, Bethesda 14, Maryland</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Embolus</b> <b>4-20-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Recent acute myocardial infarction</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary fibrosis; adhesive pericarditis; Carcinoma of the Breast</b> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 20g. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <b>February 12, 19 62</b> to <b>February 27, 19 62</b> that (I) (we) last saw the deceased alive on <b>February 27, 19 62</b> and that death occurred at <b>7:15 p.m.</b> from the causes and on the date stated above. 22a. SIGNATURE <b>Michael Field</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>Michael Field M.D.</b> 22b. DATE SIGNED <b>February 28, 1962</b> 22d. ADDRESS <b>The Clinical Center, National Institutes Of Health, Bethesda 14, Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>			23b. DATE THEREOF <b>Feb 28, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Schwartz Bros., Inc.</b>			23d. LOCATION (City, town or county) (State) <b>New York, N.Y.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Goldberg Funeral Home</b>						ADDRESS <b>4217 9th Street N.W.</b>		25a. REC'D BY REGISTRAR <b>MAR 2 '62</b>		25b. REGISTRAR'S SIGNATURE <b>C. S. H. H.</b>	

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in order to be able to identify the person

*Handwritten signature*

Goldberg Funeral Home 421 5th Street N.W.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

Item 23b, File # G206 2/9/62 iwk

02027

02009

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda, (Rural)</b> c. LENGTH OF STAY IN lb <b>20 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. NAVAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>FLORIDA</b> b. COUNTY <b>JACKSONVILLE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RT 7 BOX 518</b> d. STREET ADDRESS <b>RT 7 BOX 518</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ina Raye COKER</b>		4. DATE OF DEATH Month <b>FEB</b> Day <b>2</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) yrs. <b>9</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Jacksonville, Florida</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harvey Neil COKER</b>		14. MOTHER'S MAIDEN NAME <b>Mary R. TRIESTE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>(F) Harvey Neil COKER</b>	
17. INFORMANT <b>Same as #2 above</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congenital Heart Disease</b> <b>754.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>14 Jan.</b> 19 <b>62</b> to <b>2 Feb.</b> 19 <b>62</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>2 Feb.</b> 19 <b>62</b> , and that death occurred at <b>2:25 PM</b> on the causes and on the date stated above.			
22a. SIGNATURE <b>C.W. Bramlett</b> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <b>2 FEB. 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>C.W. BRAMLETT LCDR MC USN</b>		22b. DATE SIGNED <b>2 FEB. 1962</b>	
22d. ADDRESS <b>U.S. NAVAL HOSPITAL, BETHESDA, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Feb. 7, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>HAMPTON CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>HAMPTON, FLORIDA</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler</b>		ADDRESS <b>ROCKVILLE, MD.</b>	
25a. REC'D BY REGISTRAR <b>FEB 6 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

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Harvey Nell OWENS

(1) Harvey Nell OWENS, born as above

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C. J. DEAN, JR. MD USN

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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

02028

02010

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b> c. LENGTH OF STAY IN 1b <b>39 days.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SUBURBAN HOSPITAL.</b>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>11 ROCKVILLE</b> d. STREET ADDRESS <b>17,001 LEMAY RD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>LEONARD PETER COLANGELO</b>				4. DATE OF DEATH Month Day Year <b>Feb 21 1962</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1.2.23</b>	
9. AGE (In years last birthday) <b>39</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ELECTRONIC ENGINEER GENERAL ELECTRIC</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>NEW YORK</b>		12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>	
13. FATHER'S NAME <b>Dominic Colangelo</b>				14. MOTHER'S MAIDEN NAME <b>Unknown.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>YES 1942-1943</b>				16. SOCIAL SECURITY NO. <b>106-14-8883</b>		17. INFORMANT <b>WIFE</b> Address <b>SAME ADDRESS.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral bronchopneumonia with pulmonary abscess, lower lobes</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <b>491X</b> DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Polymyositis</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>February 12, 1962</b> to <b>February 21, 1962</b> , that (I) (we) last saw the deceased alive on <b>February 21, 1962</b> , and that death occurred at <b>6:20 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>J. Blaine Fitzgerald</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>J. Blaine Fitzgerald</b>				22d. ADDRESS <b>8218 Wisconsin Avenue Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/26/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Calvary</b>		23d. LOCATION (City, town or county) (State) <b>Chickawa New York</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler</b> Home <b>1331 East Montg. Ave. Rockville Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 26 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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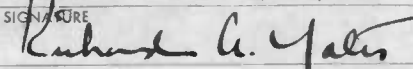
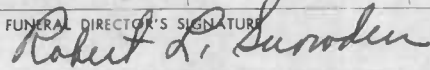

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02029

02011

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Olney</b> c. LENGTH OF STAY IN 1b <b>18 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Montgomery General</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) a. STATE <b>Md.</b> <span style="float: right;">b. COUNTY <b>Montgomery</b></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Norwood</b> d. STREET ADDRESS <b>Cl21 Silver Spring</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>BABY BOY COOK</b>		<b>4. DATE OF DEATH</b> Month <b>2</b> Day <b>1</b> Year <b>1962</b>		<b>5. SEX</b> <b>male</b> <b>6. COLOR OR RACE</b> <b>col.</b> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>1/14/62</b> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>9. AGE (In years last birthday)</b> <b>18</b> <b>IF UNDER 1 YEAR</b> Months <b>18</b> <b>IF UNDER 24 HRS.</b> Hours <b>18</b> Min. <b>18</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>			
<b>13. FATHER'S NAME</b> <b>Roland Cook</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Alice White</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b> (If yes give year or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>Hospital records</b> <span style="float: right;">Address</span>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Tracheobronchitis and broncho</b> <b>500X</b> DUE TO <b>Pneumonia</b> Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. } DUE TO (c) _____					<b>INTERVAL BETWEEN ONSET AND DEATH</b>  <b>3 hours</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify medical examiner)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> Hour a.m. _____ p.m. _____		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> _____ <b>(County)</b> _____ <b>(State)</b> _____			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>1/14/62</b> <b>12</b> <b>to</b> <b>2/1/62</b> <b>3:05am</b> <b>19</b> <b>that (I) (we) last saw the deceased alive on</b> <b>1/31/62</b> <b>19</b> <b>and that death occurred at</b> _____ <b>M</b> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b>  <b>M.D.</b>		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22b. DATE SIGNED</b> <b>2/1/62</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Richard A. Yates, M.D.</b> <b>22d. ADDRESS</b> <b>Olney, Maryland</b>			
<b>23a. BURIAL, CREMATION, REINTERMENT</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>2/2/62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Ash Memorial.</b>			
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> 		<b>ADDRESS</b> <b>Rockville, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE FEB 13 '62</b> <b>25b. REGISTRAR'S SIGNATURE</b> 			

2073297152

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

11080

23082



Montgomery

Montgomery

Mr.

Wood

18 days

only

121 Silver Spring

Montgomery General

82

1

2

18

1/1/62

col.

male

USA

Maryland

Alice White

Roland Cook

Hospital records

no

acute tracheobronchitis and pneumonia

1 hour

1/1/62 3:00am

1/31/62

1/1/62

only, Maryland

Richard A. Yates, D.D.

Sammy Brown, Jr.

John Phillips

Rockville, Md.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02030					02012				
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Olney</b> c. LENGTH OF STAY IN 1b <b>2</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Montgomery General Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Md.</b> f. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg, Md.</b> d. STREET ADDRESS <b>Warfield Rd., Rt 2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>William Riley Cook</b>					4. DATE OF DEATH Month <b>2</b> Day <b>15</b> Year <b>1962</b>				
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/15/1877</b>		9. AGE (In years last birthday) <b>84</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lumber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sawmill</b>		11. BIRTHPLACE (County & State, or foreign country) <b>North Carolina</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>James Cook</b>					14. MOTHER'S MAIDEN NAME <b>Mary Jane Hodge</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-10-8406</b>		17. INFORMANT <b>Hospital records</b> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Cancer of stomach</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis</b>									INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>DAN DO</b>		20g. (County) <b>Feb 15</b>
21. I certify that (I) (this hospital) attended the deceased from <b>DAN DO</b> , 1962 to <b>Feb 15</b> , 1962 that (I) (we) last saw the deceased alive on <b>2/14</b> , 1962, and that death occurred at <b>1:15 PM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>G.F. MEADORS, MD</b>					22b. DATE SIGNED <b>2/15/62</b>		22c. PHYSICIAN'S NAME (Type) <b>G.F. MEADORS, MD</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>2-17-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Laytonsville</b>			23d. LOCATION (City, town or county) <b>Laytonsville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis H. Barber</b> ADDRESS <b>Laytonsville, Md.</b>					25a. REC'D BY REGISTRAR DATE <b>FEB 21 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Charles L. Hume</b>		

M

73

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BP

05012

CERTIFICATE OF DEATH

05030

(M)

County of

County of

Alphonsus, Jr.  
born 11/11/1911

Alphonse, Jr.  
born 11/11/1911

11/11/1911

11/11/1911

11/11/1911

11/11/1911

U.S.

North Carolina

Samuel

James

Mary Jane Hobbs

James Cook

hospital records

11-1-1911

no



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02031

## CERTIFICATE OF DEATH

02013

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Washington, D.C.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b>		d. STREET ADDRESS <b>3830 Harrison St. N.W.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Surburban Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>EMMA C. W. CORNELL</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>3</b> Year <b>1962</b>					
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 3, 1876</b>	9. AGE (In years last birthday) <b>85</b> yrs.	IF UNDER 1 YEAR Months <b>3</b> Days <b>1962</b>	IF UNDER 24 HRS. Hours <b>3</b> Min. <b>1962</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Monroe Wigginton</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Crune</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Miss Mae Cornell, 3830 Harrison St. D.C.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO (b) <b>Hypertensive Cerebro Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <b>1-4-62</b> , 19 <b>62</b> , to <b>2-3</b> , 19 <b>62</b> that (I) ( <del>we</del> ) last saw the deceased alive on <b>2-3</b> , 19 <b>62</b> , and that death occurred at <b>6:40</b> A.M., from the causes and on the date stated above. 22a. SIGNATURE <b>Wm Fleet Luckett</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <b>William Fleet Luckett</b> 22d. ADDRESS <b>5000 Reno Rd. N.W. D.C.</b> 22b. DATE SIGNED							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>2/4/1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Resthaven Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Louisville, Ky.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Gawlers Sons</b> ADDRESS <b>1756 Pa. Ave. N.W. WASHINGTON D.C.</b>				25a. REC'D BY REGISTRAR <b>DATE FEB 6 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Thomas</b>	

(M)

02031

CERTIFICATE OF DEATH

02013

Montgomery

Bedford

Suburban Hospital

2800 Harrison St. N.W.

CORNELL

C. W.

EMMA

Feb.

82

Female white

x

Oct. 2, 1876

82

At Home

Kentucky

U.S.A.

Knoxington

Elizabeth Grate

Home

Miss Mae Cornell, 2800 Harrison St. N.W.

William West Jackson

2800 Harrison St. N.W. D.C.

Reuben Cemetery

Bedford, Ky.

2-1-1902

1786 N. Ave. N.W.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02032

02014

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Dickerson</b> c. LENGTH OF STAY IN 1b <b>80 yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Dickerson</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Dickerson</b> d. STREET ADDRESS <b>Dickerson</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <b>GRACE OLIVIA CROMWELL</b>				<b>4. DATE OF DEATH</b> Month <b>February</b> Day <b>9</b> Year <b>1962</b>													
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Aug 13, 1879</b>		<b>9. AGE</b> (In years last birthday) <b>82</b> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <th>Months</th> <th>Days</th> <th>Hours</th> <th>Min.</th> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>									
<b>13. FATHER'S NAME</b> <b>Joseph Hoyle</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Annie Hoyle</b>													
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>Richard Cromwell, Dickerson, Md</b>		<b>Address</b>									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardiovascular disease</b> DUE TO (b) <b>443X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)								<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>12 years.</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>arteriosclerosis</b>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>									
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>							
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <b>May 1949</b> , to <b>Feb 9, 1962</b> , that (I) (we) last saw the deceased alive on <b>Feb 9, 1962</b> , and that death occurred at <b>7 A.M.</b> , from the causes and on the date stated above.																	
<b>22a. SIGNATURE</b> <b>John G. Fawcett</b>						<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b>									
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>John G. Fawcett</b>						<b>22d. ADDRESS</b> <b>Boys, Md.</b>											
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>2/12/62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Monocacy</b>		<b>23d. LOCATION</b> (City, town or county) <b>Beallsville</b>		<b>(State)</b> <b>Md.</b>									
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <b>William B. Hillon</b>						<b>ADDRESS</b> <b>Barnesville, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE FEB 13 '62</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Thomas</b>							

02011

CENTRALITY OF DEATH

02002



Montgomery

Montgomery

Montgomery

Nickerson

60 Yrs

Nickerson

Maryland

Maryland

Nickerson, Nickerson, Md

John T. Fawcett

Boyd, Md.

Md.

Boydsville

Boydsville

Boydsville

Boydsville

Boydsville, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02033

CERTIFICATE OF DEATH

02015

Items 8 & 9 Film 6307 2/13/62 iwk

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN lb <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>8202 Maple Ridge Road</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>8202 Maple Ridge Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Josephine A Cywinski</b>		4. DATE OF DEATH Month Day Year <b>Feb 1 1962</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1887</b> <b>March 19, 1887</b>	9. AGE (In years last birthday) <b>74</b> Months Days <b>9 12</b>	IF UNDER 1 YEAR Hours Min. <b>5</b>	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA, Nat.</b>
13. FATHER'S NAME <b>Paul Radcka</b>			14. MOTHER'S MAIDEN NAME <b>Mary Ann</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>161-221-6304</b>		17. INFORMANT <b>John S. Cywinski-Husband-same 2d</b>		Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Paralysis</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Vascular accident</b> DUE TO (c) <b>arteriosclerosis - cerebral generalized</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Repeated previous Cerebral Vascular accidents</b>						INTERVAL BETWEEN ONSET AND DEATH <b>29 hours 4 days 5 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>12/3</b> to <b>1959</b> that (I) (we) last saw the deceased alive on <b>2/1</b> <b>1962</b> , and that death occurred at <b>11:50 PM</b> from the causes and on the date stated above.						
22a. SIGNATURE <b>Marcel J. Foret</b>		M.D. <b>MARCEL J. FORET</b>		22b. DATE SIGNED <b>2-2-62</b>		
22c. PHYSICIAN'S NAME (Type) <b>MARCEL J. FORET</b>		22d. ADDRESS <b>1746 K St NW Wash DC</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit 2/6/62</b>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Mill Creek Township Erie, Pennsylvania</b>
24 FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>			25a. REC'D BY REGISTRAR DATE <b>FEB 5 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>	

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CERTIFICATE OF DEATH

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Montgomery

Maryland

Montgomery

Bethesda

Bethesda

6202 Maple Ridge Road

6202 Maple Ridge Road

Feb 1 1952

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Civilian

A

Josephine

March 19, 1952

Female

USA, Nat.

Poland

Hungary

Mary Ann

Paul Radin

181-321-6700 John P. Civilian - Husband - same 2d

Mill Creek Township  
Elie, Pennsylvania

Calvary Cemetery

Robert A. Montgomery, Bethesda, Maryland



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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b> c. LENGTH OF STAY IN lb <b>7 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SUBURBAN</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCKVILLE</b> d. STREET ADDRESS <b>216 Spring Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ALICE</b> First Middle Last <b>DAVIS</b>				4. DATE OF DEATH <b>FEB. 25 19 62</b> Month Day Year			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>c. o. l.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/7/03</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Thomas</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Beth Thomas</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If give war or dates of service)		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Congestive heart failure</b> DUE TO (b) <b>arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						INTERVAL BETWEEN ONSET AND DEATH <b>3 mos</b> <b>3 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19.....; that (I) (we) last saw the deceased alive on.....19....., and that death occurred at.....M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Dorothy Gill</b> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Dorothy Gill</b>				22d. ADDRESS <b>Rockville, Md</b>			
23a. BURIAL, CREMATION, REMOVAL		23b. DATE THEREOF <b>2/28/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ash Memorial..</b>		23d. LOCATION (City, town or county) (State) <b>Sandy Spring, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b>				25. REC'D BY REGISTRAR <b>FEB 28 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 would be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 would be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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*Returned to the office*

*Completed and filed*

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*Completed and filed*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
02017													
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>37 days.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>55 Chevy Chase I5</b> d. STREET ADDRESS <b>1 4805 Cumberland Avenue.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Irving Maxwell Day</b>						4. DATE OF DEATH Month Day Year <b>Feb. 25th. 19 62</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/I/94</b>		9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales Engineer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Engineering</b>				11. BIRTHPLACE (County & State, or foreign country) <b>New York State</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Maxwell Warren Day</b>						14. MOTHER'S MAIDEN NAME <b>Nellie Davis</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>YES 1914-18</b>						16. SOCIAL SECURITY NO. <b>577-44-8008</b>						17. INFORMANT <b>Wife-Doris Day</b> Address <b>Same address.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RENAL FAILURE</b> <b>581.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>CHRONIC LIVER</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>2</b>										INTERVAL BETWEEN ONSET AND DEATH <b>3 C HR</b> <b>2 YR</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>JAN, 1955</b>		20g. (County) <b>FEB</b>		20h. (State) <b>1962</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>JAN, 1955</b> to <b>FEB, 1962</b> that (I) (we) last saw the deceased alive on <b>2/25</b> 19 <b>62</b> , and that death occurred at <b>3:00</b> P.M. from the causes and on the date stated above.													
22a. SIGNATURE <b>L E O I DUNNAN M.D.</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/25/62</b>					
22c. PHYSICIAN'S NAME (Type) <b>2214 WIDE AVE 1</b>						22d. ADDRESS <b>BETH. 14 MARYLAND</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/28/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Rockville, Maryland</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>						25a. REC'D BY REGISTRAR DATE <b>MAR 1 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>					

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02018

02036

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>17 Takoma Park</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban</b>		d. STREET ADDRESS <b>7131 Sycamore Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ernest Luther Daymude</b>		4. DATE OF DEATH <b>Feb. 24 1962</b>		5. SEX <b>Male</b>	
6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 29, 1895</b>	
9. AGE (In years last birthday) <b>67</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Plumbing</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William Daymude</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Cornelius Butt</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>218-16-0421</b>	
17. INFORMANT <b>Jean C. Daymude</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarct</b> Conditions, if any, which gave rise to immediate cause (b) <b>Coronary Thrombosis</b> (c) <b>sudden</b>		INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Rockville</b>		20g. (County) <b>Montgomery Co.</b>		20h. (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-27-62</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		22d. LOCATION (City, town, or country) <b>Rockville</b>		22e. (State) <b>Montgomery Co., Md.</b>	
23. FUNERAL DIRECTOR <b>Raymond A. Ziska</b>		23a. ADDRESS <b>4134 Georgia Ave.</b>		24. REC'D BY REGISTRAR <b>FEB 28 '62</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles E. ...</b>		24c. DATE <b>FEB 28 '62</b>		24d. REGISTRAR'S SIGNATURE <b>Charles E. ...</b>	

VS. A15ME  
5M 9/60

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

05018

EXHIBIT EXAMINATION CERTIFICATE OF DEATH

1. NAME

2. SEX

3. AGE

4. RACE

5. OCCUPATION

6. RESIDENCE

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE

10. CAUSE

11. MANNER

12. SIGNATURE

13. DATE

14. SIGNATURE

15. SIGNATURE

16. SIGNATURE

17. SIGNATURE

18. SIGNATURE

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33. SIGNATURE



may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02019

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>			
c. LENGTH OF STAY IN 1b <b>38 yrs</b>				d. STREET ADDRESS <b>116 Meem Ave</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ephriam</b> Middle <b>Raymond</b> Last <b>De Puy</b>				4. DATE OF DEATH Month <b>Feb</b> Day <b>4th</b> Year <b>19 62</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 17-1884</b>		9. AGE (In years lost birthday) <b>77</b> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>8</b> Days <b>17</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Justice of the Peace</b>		11. BIRTHPLACE (State or foreign country) <b>Amitville L. I. N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Talbott De Puy</b>				14. MOTHER'S MAIDEN NAME <b>Frances Moffett</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>U S Army 1910,</b>		17. INFORMANT <b>Dorothy Woods De Puy. Gaithersburg</b>		Address <b>As #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>50 2.0 Bronchial Pneumonia</b> DUE TO (b) <b>Pub. Emphysema</b> DUE TO (c) <b>Chronic Bronchitis &amp; Bronchiectasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <b>72 L</b> <b>10 yrs</b> <b>20 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.H. 7' &amp; wound</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2/1/1962</b> to <b>2/4/1962</b> that (I) (we) last saw the deceased alive on <b>2/4/1962</b> and that death occurred at <b>9:30 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Stephen N. Jones</b>				22b. DATE SIGNED <b>2/4/62</b>		22c. PHYSICIAN'S NAME (Type) <b>Stephen N. Jones</b>	
22d. ADDRESS <b>809 Viers Mill Rd. Rockville. Md.</b>				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Feb 6th 62</b>		<b>Parklawn</b>		<b>Rockville. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner. Gaithersburg. Md.</b>				25a. REC'D BY REGISTRAR <b>FEB 6 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Clifford S. Hanna</b>	

02031

CERTIFICATE OF DEATH

02031

(M)

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02038

02020

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN b <b>17 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maine</b> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Fairfield</b> d. STREET ADDRESS <b>Forest Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Donald</b> Middle <b>David</b> Last <b>Doak</b>		<b>4. DATE OF DEATH</b> Month <b>February</b> Day <b>19</b> Year <b>1962</b>		<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>August 21, 1907</b>		<b>9. AGE</b> (In years last birthday) <b>54</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Sheet Metal Worker</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maine</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Richard E. Doak</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Nichols</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> <b>16. SOCIAL SECURITY NO.</b> <b>Unascertainable</b>				<b>17. INFORMANT</b> <b>The Medical Record</b>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Respiratory Arrest</b> 434.3 DUE TO (b) <b>Ventricular Fibrillation</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) <b>Immediate post-operative pericardiectomy for Constrictive Pericarditis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)																<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>20 Minutes</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)															
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town) (County) (State)</b>							
<b>21. I certify that</b> <del>(X)</del> (this hospital) attended the deceased from <b>February 2, 1962</b> to <b>February 19, 1962</b> , that <del>(X)</del> (we) last saw the deceased alive on <b>February 19, 1962</b> , and that death occurred at <b>5:40 P.M.</b> from the causes and on the date stated above.																			
<b>22a. SIGNATURE</b>  <b>22c. PHYSICIAN'S NAME (Type)</b> <b>W. B. Berry</b>				<b>22b. DATE SIGNED</b> <b>February 20, 1962</b>				<b>22d. ADDRESS</b> <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>											
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial-transit</b>				<b>23b. DATE THEREOF</b> <b>2-21-62</b>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Riverside Cemetery</b>				<b>23d. LOCATION (City, town or county) (State)</b> <b>Ft. Fairfield, Maine</b>							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>ROBERT A. PUMPHREY</b>				<b>ADDRESS</b> <b>Bethesda, Md.</b>				<b>25a. REC'D BY REGISTRAR</b> <b>FEB 23 '62</b>				<b>25b. REGISTRAR'S SIGNATURE</b> 							

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• *Journal of Management*

1. *Introduction*

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1. *Chrysomelidae*: 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 8

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Revised - January 2-21-62 University Cemetery Ft. Belvoir, Moine

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02039

## CERTIFICATE OF DEATH

02021

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>36 J. IVER Spring</b>			
c. LENGTH OF STAY IN 1b <b>2 mos.</b>				d. STREET ADDRESS <b>11703 Highview Ave</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>BEL PKE Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>John Edward Dolan</b>				4. DATE OF DEATH <b>FEBRUARY 28 1962</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JANUARY 1, 1882</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physician</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Dolan</b>				14. MOTHER'S MAIDEN NAME <b>Unknown Bridget Cowey</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes W.W.I.</b>				16. SOCIAL SECURITY NO. <b>Yes</b>			
17. INFORMANT <b>ROSEMARY DOLAN</b>				Address <b>1703 Highview Ave, SS.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>450.0</b> TO <b>Bronchopneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Generalized arteriosclerosis</b> (c) <b>Haemia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>Unknown</b> <b>3-5 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bridge, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>August 22, 1961</b> to <b>Feb 27, 1962</b> that (I) (we) last saw the deceased alive on <b>Feb 27, 1962</b> and that death occurred at <b>12:15 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Michael Madeoff</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Feb 28 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>MICHAEL MADEOFF M.D.</b>				22d. ADDRESS <b>11406 VIERS MILL RD WHEATON MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-2-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Arlington Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Warner</b> <b>E. Pumphrey, Inc.</b>				25a. REC'D BY REGISTRAR <b>2 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur E. Howard</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02040

02022

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Mont. Co.</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Bethesda/day</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Cherry Chase</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Suburban</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Walter Ploysius Howard</i>		4. DATE OF DEATH <i>Feb. 28 1962</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <i>8/25/88</i>	9. AGE (In years last birthday) <i>73</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired private</i>		11. BIRTHPLACE (County & State, or foreign country) <i>U. S. A.</i>	
13. FATHER'S NAME <i>John Charles Howard</i>		14. MOTHER'S MAIDEN NAME <i>Marj Christine Leach</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>Unknown-Yes</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X Cerebrovascular accident</i> DUE TO (b) <i>Cerebral arteriosclerosis</i> DUE TO (c) <i>?</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Severe chronic pulmonary emphysema &amp; partial pneumothorax</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Left</i>	
20c. TIME OF INJURY Month, Day, Year <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Feb. 28, 1962</i> to <i>Feb. 28, 1962</i> , that (I) <i>(we)</i> last saw the deceased alive on <i>Feb. 28, 1962</i> and that death occurred at <i>9:45</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>George A. Gray, Jr.</i>		22b. DATE SIGNED <i>3/1/62</i>	
22c. PHYSICIAN'S NAME (Type) <i>George A. GRAY, Jr., M.D.</i>		22d. ADDRESS <i>4140 Cherry Chase Dr., Mont. Co., Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>3/3/62</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Washington, D. C.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>		25a. REC'D BY REGISTRAR <i>MAR 5 '62</i>	
ADDRESS <i>Bethesda, Maryland</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kneiss</i>	

02055

02055

Robert A. Farnham, Bethesda, Maryland

Serial 5/3/62

Mr. Oliver Deane

Washington, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02041

CERTIFICATE OF DEATH

02023

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>11 Months</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>8605 Bradmoor Drive</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> f. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>46 Bethesda</b> d. STREET ADDRESS <b>8605 Bradmoor Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>RICHARD F. ELGIN, Sr</b> First Middle Last <b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>Apr 12, 1881</b> <b>9. AGE</b> (In years last birthday) <b>80 yrs.</b> <b>IF UNDER 1 YEAR</b> Months <b>10</b> Days <b>2</b> <b>IF UNDER 24 HRS.</b> Hours Min.		<b>4. DATE OF DEATH</b> <b>Feb. 14 1962</b> <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Auto Dealer</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Retired</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b> <b>12. CITIZEN OF WHAT COUNTRY</b> <b>U. S.</b>	
<b>13. FATHER'S NAME</b> <b>Luther Elgin</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Elizabeth Bottler</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes, give war or date of service) <b>16. SOCIAL SECURITY NO.</b> <b>None</b> <b>17. INFORMANT</b> <b>Wife</b> <b>Leila G. Elgin</b> <b>Address</b> <b>Same as Item #2</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Dissecting aneurysm of the abdominal aorta</b> <b>451X</b> <b>DUE TO</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(b)</b> <b>Arteriosclerosis</b> <b>(c)</b> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <b>Coronary sclerosis - Diabetes mellitus</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>24 hrs</b> <b>6 yrs</b>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>19</b> p.m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21. I certify that (I) (this hospital) attended the deceased from June 1961, to Feb 14, 1962, that (I) (we) last saw the deceased alive on Feb 14, 1962, and that death occurred at 5:57 p.m., from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>Malcolm D. Harrison</b> M.D. <b>22c. PHYSICIAN'S NAME</b> (Type) <b>MALCOLM D. HARRISON</b>		<b>22b. DATE SIGNED</b> <b>Feb. 14, 1962</b> <b>22d. ADDRESS</b> <b>4535 Yuma St NW - Wash DC</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b> <b>23b. DATE THEREOF</b> <b>2-17-62</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Mark's Cemetery</b> <b>23d. LOCATION</b> (City, town or county) (State) <b>Frederick County, Md.</b>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>ROBERT A. PUMPHREY</b> <b>ADDRESS</b> <b>Bethesda, Md.</b> <b>25a. REC'D BY REGISTRAR</b> <b>DATE FEB 19 '62</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kimes</b>	

(M)

ROBERT A. FURNERBY

Beltsville, Md.

2-17-62

St. Mark's Cemetery

Frederick County, Md.

MARION L. HARRISON

*Marion L. Harrison*

Feb 14 62

Jan 29 62

Feb 14 62

Miss Jones St. W. - West Dr

Feb 14 1962

Generaly tolerant - Diabetes mellitus

Cerebral sclerosis

Directing manager of the  
Colonial Hotel

None

John G. Smith

Same as item 43

Elizabeth Butler

Maryland

U. S.

Leaher Eliza

into transfer

Male White

RICHARD

8605 Broadway Drive

Beltsville

11 Months

Beltsville

8605 Broadway Drive

ELIZABETH

Feb 14 62

62

02041

02043

VR A15 (4)  
ISM 7/61

2  
MEDICAL CERTIFICATION

1

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© M

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**MARYLAND STATE DEPARTMENT OF HEALTH**

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02042

## CERTIFICATE OF DEATH

02024

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN b. <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Saniterium + Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Massachusetts</u> <b>MASSACHUSETTS</b> b. COUNTY <u>Wilbraham</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>588-3</u> d. STREET ADDRESS <u>34 Oakland St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Judith Lloyd Ellicott</u> First Middle Last <b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>9-17-34</u> <b>9. AGE</b> (In years last birthday) <u>27</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>2</u> Days <u>7</u> <b>IF UNDER 24 HRS.</b> Hours <u>19</u> Min. <u>62</u>				<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>- - -</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Franklin B. Barger</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Helen Nicols</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>(If yes give number or dates of service)</u> <b>17. INFORMANT</b> <u>Charles Raymond Ellicott, III.</u> Address <u></u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension</u> DUE TO (b) <u>Nephritis</u> DUE TO (c) <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <u>Diabetes Mellitus - Brittle</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 yrs ±</u> <u>2 yrs ±</u> <u>6 wks</u>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u></u>				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u></u>		<b>20f. (City or town) (County) (State)</b> <u></u>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>2/5/1962</u> <b>to</b> <u>2/7/1962</u> <b>that (I) (we) last saw the deceased alive on</b> <u>2-7-1962</u> <b>and that death occurred at</b> <u>10:45 PM</u> <b>from the causes and on the date stated above</b> <u>Under Constant Medical Care for 2 1/2 years</u>							
<b>22a. SIGNATURE</b> <u>Robert A. Hare MD.</u> <b>M.D.</b> <b>22c. PHYSICIAN'S NAME</b> (Type) <u>Robert A. Hare MD.</u>				<b>22b. DATE SIGNED</b> <u>2-8-62</u> <b>22d. ADDRESS</b> <u>7600 Carroll Ave. T.P., Md.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>2-10-1962</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>ST. PAUL'S CHURCH CEMETERY, Chestertown, MD.</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u></u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Joseph G. Goulson</u> <b>ADDRESS</b> <u>1755 Pa. Ave. NW, Wash. D.C.</u>				<b>25a. REC'D BY REGISTRAR</b> <u>FEB 13 '62</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Hanna</u>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02043

02025

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Silver Spring</u> c. LENGTH OF STAY IN <u>7 year 2 hr</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Silver Spring</u> d. STREET ADDRESS <u>18600 16th Street</u>			
3. NAME OF DECEASED (Type or print) <u>JOHN Philip</u>		4. DATE OF DEATH Last <u>EVANS</u> Month <u>2</u> Day <u>11</u> Year <u>1962</u>		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Jan. 25, 1911</u>		9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Executive</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sears Roebuck Merchandising</u>		11. BIRTHPLACE (County & State, or foreign country) <u>St. Paul, Minnesota</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Homer A. Evans</u>				14. MOTHER'S MAIDEN NAME <u>Ethel Atkins</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>075-03-4256</u>		17. INFORMANT <u>Frank Cady</u> Address <u>8600 16th St. Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO <u>420-1</u> Conditions, if any, which gave rise to immediate cause (b) <u>Coronary sclerosis</u> (a), stating the underlying cause last. DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 Hour</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>  </u>							
20c. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>April 15, 1961</u> to <u>February 11, 1962</u> ; that (I) (we) last saw the deceased alive on <u>2/11/1962</u> , and that death occurred at <u>9:40 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Max G. Sherer</u> M.D.				22b. DATE SIGNED <u>2/11/62</u>		22c. PHYSICIAN'S NAME (Type) <u>MAX G. SHERER, MD</u>	
22d. ADDRESS <u>2025 EAST West H'way Silver Spring, Md</u>		22e. REC'D BY REGISTRAR <u>  </u>		22f. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-15-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill Cemetery</u>		23d. LOCATION (City, town or county) <u>Utica Oneida Co. New York</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumping</u> ADDRESS <u>8434 Georgia Avenue, Md</u>				25. DATE <u>FEB 15 '62</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02044				Item 2 Film G308 3/2/62 iwk				02026			
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)							
a. COUNTY <u>Montgomery</u>				a. STATE <u>md.</u>				b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY in lb <u>6 days</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>45 Bethesda</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hosp.</u>				d. STREET ADDRESS <u>9524 Milstead Drive</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH				5. AGE (In years, if birthday)			
First <u>Thomas</u> Middle <u>H</u> Last <u>Evans</u>				Month <u>2</u> Day <u>24</u> Year <u>1962</u>				66 yrs.			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/26/95</u>		9. AGE (In years, if birthday)		IF UNDER 1 YEAR	
								Months		Days	
								Hours		Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Building manager</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Pa.</u>			
13. FATHER'S NAME <u>Daniel Evans</u>				14. MOTHER'S MAIDEN NAME <u>Pamela Himm</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>WWW 1</u>				17. INFORMANT <u>Thomas, (son)</u> Address <u>311 University Blvd. S. Spring</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Heart Failure</u>								<u>4 day</u>			
443X DUE TO (b) <u>Auricular Fibrillation</u>								<u>4 day</u>			
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, (c) <u>Arterio Sclerosis &amp; High B.P.</u>								<u>10 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> to <u>Feb 24, 1962</u> that (I) (we) last saw the deceased alive on <u>Feb 24, 1962</u> and that death occurred <u>11:38 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Bradley D. Hodgkins</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>2/24/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>Bradley D. Hodgkins</u>				22d. ADDRESS <u>4413 Bradley Lane Chevy Chase Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF <u>2/28/62</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Valley View Cemetery</u>			
								23d. LOCATION (City, town or county) (State) <u>Jermyn, Pennsylvania</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR <u>1 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Robert S. Thomas</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02045

## CERTIFICATE OF DEATH

02027

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>4 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesapeake Beach</b> d. STREET ADDRESS <b>R.R. #1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Sally Owen Fitzhugh</b>		4. DATE OF DEATH Month <b>February</b> , Day <b>1</b> , Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>28 SEPT 1899</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Kentucky</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Ambrose Collins</b>	
14. MOTHER'S MAIDEN NAME <b>Betty Sublette</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)	
16. SOCIAL SECURITY NO. <b>407-18-9661A</b>		17. INFORMANT <b>HUS: Clark S. Fitzhugh, Same as #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Occlusion Arteriosclerotic Vascular Disease</b> DUE TO (b) <b>450.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>xx</b> (this hospital) attended the deceased from <b>Jan. 28, 1962</b> to <b>Feb. 1, 1962</b> that <b>xx</b> (we) last saw the deceased alive on <b>Feb. 1, 1962</b> , and that death occurred at <b>3:00 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>C.W. Bramlett</b> M.D.		22b. DATE SIGNED <b>February 1, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>C.W. BRAMLETT, LCDR MC USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>5 Feb 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hills</b>		23d. LOCATION (City, town or county) (State) <b>Prince George's Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>S.H. Hines Co.</b> ADDRESS <b>S.H. Hines Co., 2901-14th St. N.W., Washington, D.C.</b>		25a. REC'D BY REGISTRAR <b>FEB 5 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

VR A15 (4)

15M 7/61

02043

02043

(M)

Maryland

Montgomery

Chesapeake Beach

Bethesda (Rural)

Feb 11 1902

U. S. Naval Hospital

February 11 1902

Albany

Owen

Bally

60

Feb 18 1902

Demerits

Female

100

Demerits

House wife

Latex Sphincter

Ampross Colic

Feb 18 1902 H. S. Clark & Co. Inc. New York

x

Jan 11 1902

Feb 11 1902

February 11 1902

U. S. Naval Hospital, Bethesda, Md.

C. N. BRADLEY, JR. MD. USN

Prince George's

Chief Clerk

Feb 11 1902

U. S. Naval Hospital, Bethesda, Md.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02046

02028

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hosp.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>54 Chevy Chase</u> d. STREET ADDRESS <u>1 7113 46th Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>John</u> Middle <u>W.</u> Last <u>Fletcher</u>		<b>4. DATE OF DEATH</b> Month <u>February</u> Day <u>28</u> Year <u>1962</u>					
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>JAN 9, 1875</u>	<b>9. AGE</b> (in years last birthday) <u>87</u> yrs. IF UNDER 1 YEAR: Months <u>1</u> Day <u>19</u> IF UNDER 24 HRS.: Hours <u></u> Min. <u></u>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>Naturalized</u>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Builder (Retired)</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Building</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>London, Ontario, Canada</u>			
<b>13. FATHER'S NAME</b> <u>John Fletcher</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Melissa Elliott</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>—</u>		<b>17. INFORMANT</b> <u>SON</u> Address <u>Maryland</u> <u>Robert E Fletcher 4412 Walsh St Ch Ch</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4 91X</u> IMMEDIATE CAUSE (a) <u>Confluent bronchopneumonia bil-</u> DUE TO <u>ateral</u> Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. } DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b>	<b>(County)</b>	<b>(State)</b>		
<b>21. I certify</b> that (I) <u>Marvin Wadler</u> attended the deceased from <u>Feb. 20</u> 19 <u>62</u> to <u>Feb 28</u> 19 <u>62</u> , that (I) <u>(me)</u> last saw the deceased alive on <u>Feb 27</u> 19 <u>62</u> and that death occurred at <u>8A</u> M, from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Marvin Wadler</u> M.D.		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>Mar. 1, 1962</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>MARVIN WADLER</u>		<b>22d. ADDRESS</b> <u>8218 Wisconsin Ave., Bethesda, Md.</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE THEREOF</b> <u>3-3-62</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Parklawn Cemetery</u>	<b>23d. LOCATION</b> (City, town or county) <u>Montgomery County, Md.</u> (State)				
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>ROBERT A. PUMPHREY</u>		<b>ADDRESS</b> <u>Bethesda, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>MAR 5 '62</u>	<b>25b. REGISTRAR'S SIGNATURE</b> <u>Caroline S. Hanna</u>		

03058

03058

May 1, 1962  
8218 Wisconsin Ave., Bethesda, Md.

Robert A. Pumphrey  
Bethesda, Md.  
Parkland Cemetery  
Montgomery County, Md.

## CERTIFICATE OF DEATH

Reg. Dist. No.

02029

02047

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47 BETHESDA, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8034 Park Lane</u>		d. STREET ADDRESS <u>8034 Park Lane</u>	
3. NAME OF DECEASED (Type or print) <u>RALPH WALDO FOSTER</u>		4. DATE OF DEATH <u>Feb 13 1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 1, 1898</u>
9. AGE (In years last birthday) <u>63 1/2</u> yrs.		IF UNDER 1 YEAR <u>Months</u> Days <u>Hours</u> Min.	
10a. USUAL OCCUPATION (If deceased was doing during most of working life, even if retired) <u>YMCA Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>YMCA</u>	
11. BIRTHPLACE (State or foreign country) <u>Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Foster</u>		14. MOTHER'S MAIDEN NAME <u>Stella Gross</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>1917-1919</u>	
17. INFORMANT <u>THELMA FOSTER - wife - 8034 Park Lane</u>		Address <u>8034 Park Lane</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO <u>42001</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Coronary thrombus</u> DUE TO (c) <u>Atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Instantaneous</u> <u>Chronic</u> <u>chronic</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>60</u> , to <u>Feb. 13</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>Jan 25</u> , 19 <u>62</u> , and that death occurred at <u>1:59 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. W. Nicklas</u> M.D.		ADDRESS (Street, city or town, state) <u>4830 - V St N.W. Wash. D.C.</u>	
PHYSICIAN'S NAME (Type) <u>EDWARD W. NICKLAS</u>		DATE SIGNED <u>2/13/62</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/16/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>FEB 15 '62</u>	
ADDRESS <u>Bethesda, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. S. Hanna</u>	

Coroner Notified + Approved.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02048

02030

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN b <b>2 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>33 Rockville, Maryland</b> d. STREET ADDRESS <b>13203 Parkland Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William Malcolm FRYE</b>		4. DATE OF DEATH Month Day Year <b>February 17 1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>22 November 1956</b> 9. AGE (In years last birthday) yrs. <b>5</b> IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>California</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Samual M. Frye</b>		14. MOTHER'S MAIDEN NAME <b>Mary Virginia Davis</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Father: Samual M. Frye</b>		Address <b>Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>2043</b> DUE TO <b>Lobular pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Acute Lymphatic leukemia in remission</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>15 February 1962</b> , to <b>17 February 1962</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>17 February 1962</b> , and that death occurred at <b>10:25 AM</b> the causes and on the date stated above.			
22a. SIGNATURE <b>H.A. PEARSON, LCDR MC USN</b>		22b. DATE SIGNED <b>17 February 62</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>20 Feb 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn</b>	23d. LOCATION (City, town or county) (State) <b>Rockville Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	
Tyson Wheeler Funeral Home, Rockville Pike, Rockville Md.		REC'D BY REGISTRAR <b>21 '62</b>	



08000

08000

(M)

(A)

Rockville, Maryland

2 days

Reception (Hotel)

1900 Rockville Drive

U.S. Naval Hospital

February 17, 1962

1962

1962

1962

22 November 1962

1962

USA

California

1st Virginia Ave

Samuel M. Rye

Paternal: Samuel M. Rye

Paternal: Samuel M. Rye

Paternal: Samuel M. Rye

17 February 62 11:00 AM

10:25 AM

17 February 62

17 February 62

U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

Rockville

Rockville

Rockville

1931 E. Montgomery Ave.

Rockville Pike, Rockville, Md.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
02049					02031										
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Olney</b> c. LENGTH OF STAY in lb <b>4 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Montgomery General Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Olney</b> d. STREET ADDRESS <b>none</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>										
3. NAME OF DECEASED (Type or print) First Middle Last <b>George Edward Gaither</b>			4. DATE OF DEATH Month Day Year <b>Februaary 4 19 62</b>												
5. SEX <b>male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>unknown</b>		8. DATE OF BIRTH		9. AGE (In years last birthday) <b>78 yrs.</b>		IF UNDER 1 YEAR Months Days <b>19 62</b>		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
13. FATHER'S NAME <b>James Gaither</b>						14. MOTHER'S MAIDEN NAME <b>Kathryn</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>unknown</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital Records</b>		Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> 4-4-31 DUE TO (b) <b>Chronic Myocarditis &amp; Arricular fibrillation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Hypertensive Cardiovascular Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>7 yrs</b> <b>4 yrs</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Sandy Spring, Md.</b>		(County)		(State)					
21. I certify that (I) (this hospital) attended the deceased from <b>2/31/62</b> to <b>2/4/62</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>2/31/62</b> , 19 <b>62</b> , and that death occurred <b>2/4/62</b> , from the causes and on the date stated above.															
22a. SIGNATURE <b>Charles H. Ligon</b>				M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/4/62</b>							
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <b>Sandy Spring, Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (Last)		23b. DATE THEREOF <b>2/7/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion.,</b>				23d. LOCATION (City, town or county) <b>Mt. Zion, Md.</b>		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Suowder</b>				ADDRESS <b>Rockville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 13 1962</b>		25b. REGISTRAR'S SIGNATURE <b>Walter S. Thomas</b>							



Montgomery

Olney

Olney

Olney

Montgomery General Hospital

none

George

Edward

Esther

February 4

65

Male Negro

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02050

02032

<b>1. PLACE OF DEATH</b> e. COUNTY <u>Montgomery</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Wheaton</u>		c. LENGTH OF STAY IN 11 <u>5 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Bethel Nursing Home</u>				d. STREET ADDRESS <u>601 Tuckerman St. N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Sarah Jane Garden</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>Feb 21 1962</u>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>FEB 22 1874</u>	
<b>9. AGE</b> (In years last birthday) <u>87 yrs.</u>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Washington, D.C.</u>	
<b>13. FATHER'S NAME</b> <u>Charles V. Sherwood</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Emma F. Bladen</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>—</u>		<b>17. INFORMANT</b> <u>Anna D. Matter</u> <u>601 Tuckerman St. N.W. D.C.</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive heart failure</u> 4 20.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>carcinoma of breast</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> <u>20 yrs</u>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Feb 1959</u> <b>to</b> <u>Feb 21 1962</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Feb 21 1962</u> <b>and that death occurred at</b> <u>3 A.M.</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>N.F. Kreuzburg</u>				<b>22b. DATE SIGNED</b> <u>2/21/62</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>N.F. Kreuzburg</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>2/24/62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Congressional Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Washington D.C.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Arthur Walters</u>				<b>25a. REC'D BY REGISTRAR</b> <u>FEB 23 '62</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02051

Item 9 Film G307 2/26/62 ink

## CERTIFICATE OF DEATH

02033

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>D.C.</b> b. COUNTY				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban</b>				d. STREET ADDRESS <b>3819 Calvert Street, N. W.</b>				
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>C.</b> Last <b>Germano</b>				4. DATE OF DEATH Month <b>February</b> Day <b>17</b> Year <b>1962</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 17, 1883</b>	9. AGE (In years last birthday) <b>78 7/11</b> yrs.	IF UNDER 1 YEAR Months <b>7</b> Days <b>11</b>	IF UNDER 24 HRS. Hours <b>7</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired marble cutter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>private</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Un Known</b>				14. MOTHER'S MAIDEN NAME <b>Un Known</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>578-07-6281</b>		17. INFORMANT <b>Ira S. Lawyer</b> Address <b>3819 Calvert St. N.W. - City</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial failure, acute</b> DUE TO (b) <b>convalescent coronary infarction</b> DUE TO (c) <b>coronary sclerosis.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b> <b>2 d.</b> <b>8 years</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>anular carcinoma, descending colon</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 17, 1962</b> to <b>Feb 17, 1962</b> , that (I) (we) last saw the deceased alive on <b>Jan 17, 1962</b> , and that death occurred at <b>5:00 P.M.</b> from the causes and on the date stated above.								
22a. SIGNATURE <b>James A. Cannon Jr. M.D.</b>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>JAMES A. CANNON JR.</b>			22d. ADDRESS <b>3141 34th St. N.W. Wash. D.C.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>20 Feb. 1962</b>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <b>WASHINGTON NAT. Cem.</b>		23d. LOCATION (City, town or county) (State) <b>MARYLAND</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. Don Roth</b>			ADDRESS <b>2224 Wise Ave. N.W.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 23 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thoma</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02052

## CERTIFICATE OF DEATH

02034

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN b <b>41 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda Md.</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> d. STREET ADDRESS <b>5400 42nd Ave.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>John William Gessner</b> First Middle Last <b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>Caucasian</b> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>23 October 1875</b> <b>9. AGE</b> (In years last birthday) <b>86</b> yrs. <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>U.S. Navy</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		<b>4. DATE OF DEATH</b> <b>February 8 19 62</b> Month Day Year <b>13. FATHER'S NAME</b> <b>GESSNER, John M.</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>FITZMAURICE, Mary</b> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>yes</b> <b>16. SOCIAL SECURITY NO.</b> <b>S-A and WWI</b> <b>17. INFORMANT</b> <b>Bernard F. GESSNER (Son) Same as #2</b> <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pyelonephritis acute, bilateral</b> <b>6000</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <b>Infection - Myocardium</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <b>19</b> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)		<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>30 December, 1961</b> to <b>8 February, 1962</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>8 February, 1962</b> , and that death occurred at <b>1748PM</b> from the causes and on the date stated above. <b>22a. SIGNATURE</b> <b>W. F. WARRENDER</b> M.D. <b>22b. DATE SIGNED</b> <b>9 Feb. 1962</b> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>W. F. WARRENDER LT MC USN</b> <b>22d. ADDRESS</b> <b>U.S. NAVAL HOSPITAL, BETHESDA MD.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b> <b>23b. DATE THEREOF</b> <b>2-12-62</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>National Cemetery</b> <b>23d. LOCATION (City, town or county)</b> (State) <b>West St., Annapolis Maryland</b>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>John Taylor</b> <b>25a. REC'D BY REGISTRAR</b> <b>FEB 13 '62</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>L. Kiana</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02053

## CERTIFICATE OF DEATH

Reg. Dist. No.

02035

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>45 BETHESDA</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>		d. STREET ADDRESS <u>1 9513 SINGLETON DRIVE</u>	
3. NAME OF DECEASED (Type or print) First <u>JANE</u> Middle <u>A.</u> Last <u>GIBBONS</u>		4. DATE OF DEATH Month <u>2</u> Day <u>26</u> Year <u>1962</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/16/85</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>IRELAND</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JOHN REED</u>		14. MOTHER'S MAIDEN NAME <u>BRIDGET HANSBURY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-40-6090B</u>	
17. INFORMANT <u>John McTernan</u>		Address <u>7110 Belmont Washington, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL HEMORRHAGE</u> DUE TO (c) <u>HYPERTENSION</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 MINS.</u> <u>4 DAYS.</u> <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>GENERALIZED ARTERIOSCLEROSIS; UREMIA.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>FEB. 22</u> , 19 <u>62</u> , to <u>FEB. 26</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>FEB. 26</u> , 19 <u>62</u> , and that death occurred at <u>5:40 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph D. Connor</u>		M.D. <u>9420 Old Georgetown Road, Bethesda, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Joseph D. Connor, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAR-1-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u>		ADDRESS <u>3821-14th St. N.W., Wash. D.C.</u>	
24a. REC'D BY REGISTRAR <u>DATE FEB 28 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Barbara E. Hume</u>	

CERTIFICATE OF DEATH

2003

<p>1. NAME OF DECEASED <i>John A. Smith</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. AGE <i>45</i></p>	
<p>4. DATE OF DEATH <i>Jan 15 1903</i></p>		<p>5. TIME OF DEATH <i>10:30 AM</i></p>		<p>6. PLACE OF DEATH <i>Home</i></p>	
<p>7. CAUSE OF DEATH <i>Heart Disease</i></p>		<p>8. DISEASE OR INJURY <i>Myocardial Infarction</i></p>		<p>9. MANNER OF DEATH <i>Natural</i></p>	
<p>10. SIGNATURE OF PHYSICIAN <i>Dr. J. B. Green</i></p>		<p>11. SIGNATURE OF WITNESS <i>John A. Smith</i></p>		<p>12. SIGNATURE OF DECEASED <i>John A. Smith</i></p>	
<p>13. SIGNATURE OF REGISTRAR <i>John A. Smith</i></p>		<p>14. SIGNATURE OF CLERK <i>John A. Smith</i></p>		<p>15. SIGNATURE OF JURY <i>John A. Smith</i></p>	

MAKLAND STATE DEPARTMENT OF HEALTH-BATHING 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
02054					02036					
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>18 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>47X-3</u> d. STREET ADDRESS <u>1040 Newton Street, N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>Antoinette Elizabeth Grady</u>					<b>4. DATE OF DEATH</b> Month <u>February</u> Day <u>6</u> Year <u>1962</u>					
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> SEPARATED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>December 5, 1887</u>		<b>9. AGE</b> (In years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired - National Geographic</u>					<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>District of Columbia</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>James Kelly</u>					<b>14. MOTHER'S MAIDEN NAME</b> <u>Eda Gier Geier</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>					<b>16. SOCIAL SECURITY NO.</b> <u>579-48-80</u>					
<b>17. INFORMANT</b> <u>Washington Sanitarium and Hospital Records</u>					<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> <u>420.0</u> DUE TO <u>Congestive Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>  </u>					
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>					<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>					<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour a.m. <u>  </u> p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b> <u>  </u> <b>(State)</b> <u>  </u>		
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Dec 19, 1961</u> <b>to</b> <u>Feb 6, 1962</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Feb 5, 1962</u> <b>and that death occurred at</b> <u>2 PM</u> <b>from the causes and on the date stated above.</b>										
<b>22a. SIGNATURE</b> <u>Boris Rabkin</u> M.D.					<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>2/6/62</u>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>BORIS RABKIN</u>					<b>22d. ADDRESS</b> <u>1019 University Blvd East, Silver Spring, Md.</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>2/9/62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Fort Lincoln</u>		<b>23d. LOCATION</b> (City, town or county) <u>Colmar Manor, Md.</u> <b>(State)</b> <u>  </u>				
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Kalley's Funeral Home, Inc.</u>					<b>ADDRESS</b> <u>Mt. Rainier, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>  </u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>  </u>	







# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02055

02037

FOR STATE  
HEALTH DEPT.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <span style="float: right;"><b>MARYLAND</b></span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b> <span style="float: right;">c. LENGTH OF STAY IN 1b <b>DOA</b></span> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. Naval Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Virginia</b> <span style="float: right;">b. COUNTY <input checked="" type="checkbox"/></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fredericksburg</b> <span style="float: right;"><b>83x-3</b></span> d. STREET ADDRESS <b>215 Frazier Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Elwood Nathan Gray</b>			<b>4. DATE OF DEATH</b> Month Day Year <b>February 25 1962</b>				
<b>5. SEX</b> <b>male</b>		<b>6. COLOR OR RACE</b> <b>Negro</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <b>September 7, 1941</b>		<b>9. AGE</b> (In years last birthday) <b>20</b> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>U.S. Marine Corps</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Hustle, Virginia</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>			
<b>13. FATHER'S NAME</b> <b>James Hyland Gray</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Susie Anna (Maiden name unknown)</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>yes</b> (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>228-50-0491</b>		<b>17. INFORMANT</b> <b>Marine Corps Records</b> <span style="float: right;">Address</span>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subdural hemorrhage</b> DUE TO (b) <b>Cerebral hemorrhage + laceration</b> DUE TO (c) <b>Fracture of skull - auto accident</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>11 hrs</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 1b.) <b>Driver of auto involved in accident</b>					
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>1:00 2-25-62</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>US 301, 1 mile N. of Port Royal Va., King George, Va.</b>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <b>Frank J. Broschart, M.D.</b>			<b>DATE SIGNED</b> <b>25 February 1962</b>				
<b>EXAMINER'S NAME</b> (Type) <b>Frank J. Broschart, M.D.</b>			<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>Address</b> (Street, city, town, or county) <b>Gaithersburg, Maryland</b>				
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>3-2-62</b>		<b>22c. NAME OF CEMETERY OR CREMATOR</b> <b>Antioch Baptist Church Cemetery</b>			
<b>23. FUNERAL DIRECTOR</b> <b>Edwards Funeral Home, Bowling Green, Va.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE MAR 5 '62</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>William S. Evans</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10-10-01 BY 60322 UCBAW

DATE 10-10-01 BY 60322 UCBAW

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02056

## CERTIFICATE OF DEATH

02038

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>34 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		d. STREET ADDRESS <b>5733 Crawford Drive</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Harriett Mackall</b>		First Middle Last <b>Griffith</b>		4. DATE OF DEATH <b>Feb. 8 19 62</b>		Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 11, 1870</b>		9. AGE (In years last birthday) <b>91 yrs.</b>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>David Griffith</b>			14. MOTHER'S MAIDEN NAME <b>Annie S. Taylor</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>W. Basil Mobley, Derwood, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>bronchopneumonia</b> 4222 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>congestive heart failure</b> DUE TO (c) <b>arteriosclerotic cardiovascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>33 days</b> <b>years</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>uremia</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>NONE</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 30, 1961</b> to <b>Feb 8, 1962</b> , that (I) <b>(two)</b> last saw the deceased alive on <b>Feb 8, 1962</b> , and that death occurred at <b>9 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Stephen C. Cromwell</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2-8-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stephen C. Cromwell</b>				22d. ADDRESS <b>615 W. Montgomery Ave Rockville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/10/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rockville Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Rockville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>				25a. REC'D BY REGISTRAR <b>FEB 13 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



22003

08003

MONTEGOMERY

Maryland

ROCKVILLE

Leeds

24 days

Rockville

Suburban Hospital

5723 Crawford Drive

Hartford Hospital

Griffin

Feb.

02

Female

White

June 11, 1970

01

None

None

Maryland

USA

David G. Gellin

Ann S. Taylor

Member

No

None

W. Basil Noble, Potomac, Maryland

*Handwritten notes:*  
The record is in the  
Baptist Church  
at Rockville, Maryland  
on June 11, 1970.

None

Stephen G. Gellin

Stephen G. Gellin

Burial

2/10/71

Rockville Cemetery

Rockville, Maryland

Robert A. Humphrey, Bethesda, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02039

02057

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>1 month 7 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Resmor Sanitarium, 5721 Grosvenor Lane</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>5000 Westpath Terrace</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Charles Frederick HALL</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>2</u> Year <u>1962</u>		5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 22, 1874</u>		9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GRAIN DEALER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>CANADA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Elihu HALL</u>		14. MOTHER'S MAIDEN NAME <u>JANE Culbert</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNKNOWN</u>			
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>LEONARD HALL (Son) - 5000 Westpath Terrace, Washington D.C.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, lobar, Rt lower lobe</u> 3 31X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebrovascular accident</u> DUE TO (c) <u>6 wks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremia; Arteriosclerotic Heart Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (the hospital) attended the deceased from <u>Oct 7, 1961</u> to <u>2-2-1962</u> that (I) (we) last saw the deceased alive on <u>2-1-1962</u> and that death occurred at <u>6:59 AM</u> , from the causes and on the date stated above.		22a. SIGNATURE <u>Stephen W. DeJter</u> M.D. 22b. DATE SIGNED <u>2-2-62</u>		22c. PHYSICIAN'S NAME (Type) <u>STEPHEN W. DEJTER, M.D.</u>	
22d. ADDRESS <u>6719 WILSON LA, BETHESDA, MD.</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-5-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Mem. Cemetery</u>	
23d. LOCATION (City, town or county) (State) <u>Annapolis, Maryland</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>		25a. REC'D BY REGISTRAR <u>FEB 7 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	



(M)

05037

05037

Montgomery

Montgomery

Montgomery

Montgomery

Reserve Lieutenant Colonel, 2nd Cavalry, 1st Cavalry Division

Reserve Lieutenant Colonel, 2nd Cavalry, 1st Cavalry Division

Charles Y. Fitch, Jr. Major, 1st Cavalry, 1st Cavalry Division

Nov. 22, 1874

Nov. 22, 1874

General Order

General Order

Elm. Hall

Elm. Hall

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General Order, 1st Cavalry, 1st Cavalry Division

General Order, 1st Cavalry, 1st Cavalry Division

Nov. 22, 1874

Nov. 22, 1874

Nov. 22, 1874

General Order, 1st Cavalry, 1st Cavalry Division

Nov. 22, 1874

Nov. 22, 1874

General Order, 1st Cavalry, 1st Cavalry Division

General Order, 1st Cavalry, 1st Cavalry Division



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02058  
CERTIFICATE OF DEATH  
02040

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b> c. LENGTH OF STAY IN 1b <b>1 hour</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Washington D.C.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b> d. STREET ADDRESS <b>707 G.-St. SE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>KIMBERLY LEE HAM</b>		4. DATE OF DEATH Month <b>February</b> Day <b>18</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>18 February 1962</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>- - - -</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - -</b>	9. AGE (In years last birthday) <b>1</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <b>Montgomery, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Ralph Ham</b>		14. MOTHER'S MAIDEN NAME <b>Virginia Lee Zacny</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>- - - -</b>		16. SOCIAL SECURITY NO. <b>- - - -</b>	
17. INFORMANT <b>Father: Charles Ralph HAM Same as #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Neonatal Death</b> DUE TO <b>773.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>- - - -</b> (c) <b>- - - -</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>- - - -</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>10</b> (this hospital) attended the deceased from <b>18 February 1962</b> to <b>18 February 1962</b> , that <b>11</b> (we) last saw the deceased alive on <b>18 February 1962</b> , and that death occurred at <b>6:30 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>F.A. Schulaner</b>		22b. DATE SIGNED <b>18 February 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>F.A. SCHULANER, LT MC USN</b>		22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>20 FEB 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MOUNT OLIVET</b>		23d. LOCATION (City, town or county) (State) <b>WASHINGTON, D. C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers</b>		25a. REC'D BY REGISTRAR <b>FEB 21 1962</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>		25c. ADDRESS <b>11th ST SE WASHINGTON DC</b>	

2-001203

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J. E. McWHIRTER

ENVIRONMENTAL SCIENCE

02041

REMOVAL (Specify)  
Burial-transit 2-25-62

Ivy Hill Cemetery

Et. Airy. Penna.

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

ROBERT A. PUMPHREY

Bethesda, Md.

25a. REC'D BY REGISTER  
DATE JAN 1 '62

Arthur L. Kenna

VR A15 (4)  
15M 9/59

52-1-1-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02060

02042

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>46 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>6408 Red Wing Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Wendell Deady Hance</b> First Middle Last				<b>4. DATE OF DEATH</b> <b>February 18, 1962</b> Month Day Year			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>November 4, 1913</b> 9. AGE (In years last birthday) <b>48 yrs.</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Economist</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Government</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Illinois</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Oscar M. Hance</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Anna Deady</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>YES WW II</b>				<b>16. SOCIAL SECURITY NO.</b> <b>Unascertainable</b>			
<b>17. INFORMANT</b> <b>The Medical Records</b> <b>The Clinical Center, Bethesda 14, Maryland</b>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypernephroma</b> DUE TO (b) <b>Leurocristine toxicity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Fever of unknown origin</b> <b>Malnutrition secondary to cancer</b>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 years</b> <b>2 weeks</b> <b>2 weeks</b> <b>2 months</b>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that I (this hospital) attended the deceased from January 3, 1962 to February 18, 1962, that I (we) last saw the deceased alive on February 18, 1962, and that death occurred at 10:00 p.m. from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>Richard S. Rivlin, M.D.</b>				<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/> <b>February 19, 1962</b>		<b>22b. DATE SIGNED</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Richard S. Rivlin, M.D.</b>				<b>22d. ADDRESS</b> <b>The Clinical Center, National Institutes Of Health, Bethesda 14, Md.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>CREMATION</b>		<b>23b. DATE THEREOF</b> <b>2-20-62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Lees Crematory</b>		<b>23d. LOCATION (City, town or county) (State)</b> <b>Washington D.C.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>J. W. Lee</b>				<b>ADDRESS</b> <b>300 4th St. N.E. Wash. D.C.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE FEB 23 '62</b>	
				<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hance</b>			

2450

02059



1900



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02061

02043

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>5004 Keokuk St.</b>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 Chevy Chase</b> d. STREET ADDRESS <b>5004 Keokuk Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First <b>KATE</b> Middle <b>C</b> Last <b>HANSHEW</b>			<b>4. DATE OF DEATH</b> Month <b>Feb.</b> Day <b>25,</b> Year <b>1962</b>		
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
<b>8. DATE OF BIRTH</b> <b>12/23/1874</b>		<b>9. AGE</b> (In years last birthday) <b>87 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months <b>2</b> Days <b>2</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> -----		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Washington, D. C.</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>					
<b>13. FATHER'S NAME</b> <b>Charles J. Brewer</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Annie S. Divine</b>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>577-10-7819D</b>		<b>17. INFORMANT</b> Address <b>Rose L. Hanshaw-daughter-same 2d</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Sanguine of right foot</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Thrombosis of tibial artery</b> (c) <b>Generalized arteriosclerosis</b>					
<b>19. INTERVAL BETWEEN ONSET AND DEATH</b> <b>24 hours</b>					
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>Arteriosclerotic cardiovascular disease</b>					
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b>		<b>20g. (County)</b>		<b>20h. (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>1952</b> <b>to</b> <b>February 25, 1962</b> <b>that (I) (we) last saw the deceased alive on</b> <b>February 25, 1962</b> , <b>and that death occurred at</b> <b>12:12 PM</b> <b>from the causes and on the date stated above.</b>					
<b>22a. SIGNATURE</b> <b>Alfred Baer, M.D.</b>		<b>22b. DATE SIGNED</b> <b>Feb. 25, 1962</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>ALFRED BAER, M.D.</b>	
<b>22d. ADDRESS</b> <b>730 24th St. NW. Washington 7 D.C.</b>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>2/27/62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Olivet Cemetery</b>	
<b>23d. LOCATION</b> (City, town or county) <b>Frederick, Maryland</b>		<b>23e. (State)</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Robert A. Pumphrey, Bethesda, Maryland</b>		<b>25a. REC'D BY REGISTRAR</b> DATE <b>MAR 1 1962</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Wm. S. Thomas</b>	



02061

05043

Montgomery

Montgomery

Grey Chase

Grey Chase

5000 Keokuk St.

5000 Keokuk Street

DATE

HANSEN

Feb. 22, 1962

62

Female White

Female White

Hansen

Hansen, D. W.

Charles J. Hansen

Charles J. Hansen

STATION 10000, Hansen, Charles J.

Feb. 22, 1962

x

Oliver Cemetery

Report of Burial, Hansen

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		e. STATE		b. COUNTY	
Montgomery		BETHESDA		MARYLAND		Montgomery	
c. LENGTH OF STAY IN 1b		54 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		X GAITHERSBURG	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
SUBURBAN HOSPITAL				ROUTE #3			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
MINNA S. HANSON				2 23 19 62			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <td colspan="2">10/23/88</td>		10/23/88	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
Housewife				73 yrs.		Months Days Hours Min.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
EMIL GEORGE SCHAFER				MARY C. WALTER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
NO		UNK.		SON ROBERT		6008 KIABY RD BETH	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)						2 DAYS	
174X DUE TO Uremia							
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.						1 WEEK	
DUE TO RENAL FAILURE							
DUE TO CARCINOMA UTERUS						3 MOS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FRACTURE Left Hip							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
		O					
20c. TIME OF INJURY		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Month, Day, Year		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
Hour a.m. p.m.		19					
21. I certify that (I) (this hospital) attended the deceased from AUG 17, 1961, to FEB 23 1962, that (I) (we) last saw the deceased alive on FEB 22 1962, and that death occurred at 5AM, from the causes and on the date stated above.							
22a. SIGNATURE				22b. DATE SIGNED			
Robert G. Brewer				2/23/62			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
ROBERT GEORGE BREWER				8218 WISCONSIN AVE BETHMD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
Cremation		2/23/62		1331 Ft. Lincoln		Prince George Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Tyson Wheeler Funeral Home Rockville, Md.				DATE FEB 26 '62		Arthur S. Kraus	

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WASHINGTON D.C. 20540

CHAPTER 1

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GENERAL FUTURE

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Robert George Thomas 818 Wisconsin Ave NW

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02063 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02045

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Mmtg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Faithersburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Faithersburg</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>901 Letts Ave</u>				d. STREET ADDRESS <u>901 Letts Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Robert Neal Hardy</u>				4. DATE OF DEATH <u>Feb 12 1962</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-2-62</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <u>10</u>		IF UNDER 1 YEAR <u>10</u> Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>md</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Donald Hardy</u>				14. MOTHER'S MAIDEN NAME <u>Yvonne Welling</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>I</u>				16. SOCIAL SECURITY NO. <u>Yvonne Hardy (mother)</u>			
17. INFORMANT <u>Ilene</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> 763-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>upper Respiratory Infection</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschak</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschak</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>2-14-62</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>				22d. LOCATION (City, town, or country) (State) <u>Arlington Va</u>			
23. FUNERAL DIRECTOR <u>Ernest B. Garbur, Faithersburg Md</u>				24a. REC'D BY REGISTRAR <u>DATE FEB 14 '62</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>							

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02064

02046

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>		d. STREET ADDRESS <b>152 West Main Street</b>	
3. NAME OF DECEASED (Type or print) <b>Richard Cresson Harlow</b>		4. DATE OF DEATH <b>February 19, 1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October, 19, 1889</b>
9. AGE (In years last birthday) <b>72 yrs.</b>		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Louis Harlow</b>		14. MOTHER'S MAIDEN NAME <b>Eugenia Pritchett</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>332 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Thrombosis</b> DUE TO (c) <b>Arteriosclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>10</b> (this hospital) attended the deceased from <b>Jan. 13, 1962</b> , to <b>Feb. 19, 1962</b> that <b>14</b> (we) last saw the deceased alive on <b>Feb. 19, 1962</b> and that death occurred at <b>1:20 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>James J. Cavanagh</b> M.D.		22b. DATE SIGNED <b>February 19, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>JAMES J. CAVANAGAH LT MC USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-22-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Pine Groove Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>S. Sterling, Pa.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. MYERS</b> Funeral Home, Westminster, Md.		25a. REC'D BY REGISTRAR DATE <b>FEB 21 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles S. Thomas</b>			

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150 West Main Street

U. S. Naval Hospital

October 19, 1988

Continued

Pennsylvania

Phyllis Thomas

John Thomas

Hospital Records

To

Jan. 19, 1988

Page 10

U. S. Naval Hospital

U. S. Naval Hospital

Continued

U. S. Naval Hospital

U. S. Naval Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02047

02065

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>7 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>North Carolina</b> b. COUNTY <b>Hudson</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Box 475</b> d. STREET ADDRESS <b>Box 475</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Lula Macbelle Harris</b>		4. DATE OF DEATH Month Day Year <b>February 8, 1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 3, 1908</b>
9. AGE (In years last birthday) <b>53 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Textile weaver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Textile</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Augustus Benfield</b>		14. MOTHER'S MAIDEN NAME <b>Kate Mundy</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>241-05-1866</b>	
17. INFORMANT <b>The Medical Record</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cardiac failure</b> <b>420.0</b> DUE TO <b>heart</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Acute Myelogenous Leukemia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1 month</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>February 1, 1962</b> to <b>February 8, 1962</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>February 8, 1962</b> and that death occurred at <b>4:15 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert H. Levin</b> M.D.		22b. DATE SIGNED <b>February 8, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert H. Levin</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL, SPECIFIC <b>BURIAL</b>		23b. DATE THEREOF <b>FEB. 11/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>LENOR, NORTH CARO.</b>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Martin W. Hysong</b> ADDRESS <b>1300 N. N.W. Wash. D.C.</b>		25. REC'D BY REGISTRAR <b>Feb 13 '62</b>	
25a. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		25b. REGISTRAR'S SIGNATURE	



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Veronica L. Johnson

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02066

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mntg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ulnsey</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>	
c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		d. STREET ADDRESS <u>512 Dornier Cwz</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Montg General Hosp</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Violet Elizabeth Hawkins</u>	4. DATE OF DEATH <u>Feb 17 1962</u>	5. SEX <u>Female</u> 6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>4-7-1913</u>	9. AGE (In years last birthday) <u>48</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchandise Manager</u>	
11. BIRTHPLACE (State or foreign country) <u>Spotsylvania Co. Va</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>Huston Acors</u>	
14. MOTHER'S MAIDEN NAME <u>Brooks Nolie</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Florence Heplin</u> Address <u>801 N. Boulevard St Richmond VA</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE <u>Contusions med. oblongata - Subarachnoid hemorrhage</u> (b) <u>Fracture 3rd &amp; 4th C. V. - hemoperitoneum hem. 250 cc</u> (c) <u>Multiple laceration of spleen &amp; liver - crushed chest, rt</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Auto accident - driver</u>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <u>6:40 p.m. 2-17 1962</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> <u>at work</u>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>md R-29</u>	
20f. (City or town) <u>Simpsonville Howard md</u>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-20-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Arlington-Arlington Co. Virginia</u>	
23. FUNERAL DIRECTOR <u>Raymond A. Jiska</u> ADDRESS <u>34 Georgia Ave.</u>		24a. REC'D BY REGISTRAR <u>DATE FEB 21 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		24c. REGISTRAR'S NAME	

THE STATE  
REVENUE

(M)

(A)

THE STATE  
REVENUE

WALTER E. BUNNELL, INC., 2121 BUNNELL, N.Y.

1-20-62

WALTER E. BUNNELL, INC., 2121 BUNNELL, N.Y.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02049

02067

Item 4 Film G307 2/26/62 iwk

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>22 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> d. STREET ADDRESS <u>1 Shady Grove Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Herbert</u> Middle <u>H.</u> Last <u>Heflin</u>				<b>4. DATE OF DEATH</b> Month <u>Feb</u> Day <u>18</u> Year <u>1962</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>4/10/80</u>	
<b>9. AGE</b> (In years last birthday) <u>81</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>0</u> Days <u>0</u>		<b>11. IF UNDER 24 HRS.</b> Hours <u>0</u> Min. <u>0</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Guard. John Hopkins</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>John Hopkins</u>			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Virginia</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>			
<b>13. FATHER'S NAME</b> <u>W. C. Heflin</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Carnie Thayer</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>212-14-6725</u>		<b>17. INFORMANT</b> <u>Maggie Heflin</u>		<b>18. ADDRESS</b> <u>Same as above</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary occlusion</u> (b) <u>essential hypertension</u> (c) <u>arteriosclerotic cardiovascular disease</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>			
<b>20c. TIME OF INJURY</b> Hour <u>19</u> a.m. <u>19</u> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>October 1954</u> to <u>Feb. 18, 1962</u> , that (I) (we) last saw the deceased alive on <u>Feb. 18, 1962</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Stephen C. Cromwell</u> M.D.				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>2-18-62</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Stephen C. Cromwell, M.D.</u>				<b>22d. ADDRESS</b> <u>Rockville, Md.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>2/21/62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Monocacy Cemetery</u>		<b>23d. LOCATION (City, town or county)</b> (State) <u>Beallsville, Maryland</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Tyson Wheeler</u>		<b>ADDRESS</b> <u>1331 East Montgomery Ave. Rockville, Maryland</u>		<b>25a. REC'D BY REGISTRAR</b> <u>FEB 21 '62</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Kraus</u>	

05013

05013



*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02068

02050

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>53 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Tennessee</u> b. COUNTY <u>Greenville</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenville</u> d. STREET ADDRESS <u>615 Franklin Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Sue Hite</u>		4. DATE OF DEATH Month Day Year <u>February 19 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 12, 1928</u>
9. AGE (In years last birthday) <u>34 yrs.</u>		IF UNDER 1 YEAR Months Days <u>18 months</u>	IF UNDER 24 HRS. Hours Min. <u>2 weeks</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Tennessee</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Thomas Daniel Boles</u>	
14. MOTHER'S MAIDEN NAME <u>Anna Flora Kesterson</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>410-34-4415</u>		17. INFORMANT <u>The Medical Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Breast with Metastases</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that <u>X</u> (this hospital) attended the deceased from <u>December 28, 1961</u> , to <u>February 19, 1962</u> , that <u>(X)</u> (we) last saw the deceased alive on <u>February 19, 1962</u> , and that death occurred at <u>8:25 A.M.</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Michael Field</u> M.D. 22b. DATE SIGNED <u>February 19, 1962</u> 22c. PHYSICIAN'S NAME (Type) <u>Michael Field, M.D.</u> 22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>2/19/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>--</u>		23d. LOCATION (City, town or county) (State) <u>Greenville, Tennessee</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H.Hines Co.-2901 14th St., N.W. Wash.</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 21 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02069

02051

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Chevy Chase</i>				c. LENGTH OF STAY IN 1b <i>2 years</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>6900 Strathmore Street</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Agnes Ferguson Hopkins</i>		First Middle Last		4. DATE OF DEATH Month Day Year <i>Feb 3 1962</i>			
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct. 29 1905</i>	
9. AGE (In years last birthday) <i>56 yrs.</i>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Administrative</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Govt</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Glasgow Scotland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Robert F. Ferguson</i>				14. MOTHER'S MAIDEN NAME <i>Agnes J. Arthur</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>579-46-0657</i>		17. INFORMANT Address <i>Mrs. Agnes Ferguson 6900 Strathmore St</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic carcinoma</i> DUE TO (b) <i>Carcinoma of right breast</i> DUE TO (c) <i>Emphysema</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <i>Emphysema</i>						INTERVAL BETWEEN ONSET AND DEATH <i>5 years</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>					
20c. TIME OF INJURY Month, Day, Year Hour e.m. <i>None</i> 19 <i>62</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>9/28</i> , 19 <i>61</i> , to <i>2/3</i> , 19 <i>62</i> , that (I) (we) last saw the deceased alive on <i>2/3</i> , 19 <i>62</i> , and that death occurred <i>2/3</i> M, from the causes and on the date stated above.							
22a. SIGNATURE <i>John B. Umhau</i> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>2/3/62</i>	
22c. PHYSICIAN'S NAME (Type) <i>JOHN B. UMHAU</i>				22d. ADDRESS <i>8805 Conn. Ave. N.W. 15 NW</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE THEREOF <i>2/6/62</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Suitland, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Company</i>				ADDRESS <i>2901 14th St. N.W.</i>		25a. REC'D BY REGISTRAR DATE <i>Feb 6 62</i>	
						25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

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STATE OF TEXAS

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Chas. C. Cress

6000 - 6000 - 6000

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John W. Cress, Attorney at Law, Houston, Tex.

The S. H. Cress Company

2001 Main St. Houston, Tex.  
Telephone 9,000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02070

## CERTIFICATE OF DEATH

02052

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>1 hr. 40 min.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>8310-16th St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edythe</u> Middle <u>MAY</u> Last <u>Hoppe</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>4</u> Year <u>1962</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/21/91</u>		9. AGE (In years last birthday) <u>70</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>WASH. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>(unknown)</u>				14. MOTHER'S MAIDEN NAME <u>FLORENCE C. FITCH</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Lloyd F. Hoppe</u>		Address <u>2D.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerosis, generalised</u> (c) <u>Hypertension, mod. severe</u> DUE TO causa test.							INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs +</u> <u>10 yrs +</u> <u>10 yrs +</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>					
20c. TIME OF INJURY Month, Day, Year Hour e.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> to <u>Feb 4</u> , 1962, that (I) (we) last saw the deceased alive on <u>Feb 4</u> , 1962, and that death occurred at <u>9:30</u> p.m. from the causes and on the date stated above.							
22a. SIGNATURE <u>Edward Aleff</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2.5.62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stewart Clapp MD</u>				22d. ADDRESS <u>4740 Chevy Chase Dr. Chevy Chase 15 Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-7-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Suitland Prince Georges Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>				ADDRESS <u>434 Georgia Ave</u>		25a. REC'D BY REGISTRAR <u>FEB 7 '62</u>	
Warner E. Humphrey, Inc. Silver Spring, Md.				25b. REGISTRAR'S SIGNATURE <u>Charles L. House</u>			

57050

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
02071				Item 2 Film G307 2/19/62 iwk				Stema 3, 13 + 14 - Film H-352-5/28/64			
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)									
a. COUNTY		Montgomery		MARYLAND		b. STATE		Md.		b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Kensington		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		1 Kensington Tokoma Park		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Carroll Hall Sanitarium									
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month Day Year	
Caroline		Homozelle		Mason		Hornor		Feb. 9, 1962		19	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
F.		W.		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		June 8, 1871		90 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Housewife				West Va.		U.S.A.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
Unknown		Joseph Hamble Mason		Unknown		Gertrude Carr					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
No				Hospital Recd.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Carcinoma of urinary bladder									
1 81.0 DUE TO											
Conditions, if any, which gave rise to immediate cause (b)											
(c), stating the underlying cause last. DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
Hour e.m. p.m.		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
19											
21. I certify that (I) (this hospital) attended the deceased from 1950 to 9 Feb 1962 that (I) (we) last saw the deceased alive on 3 Feb 1962 and that death occurred at 2:30 A.M. from the causes and on the date stated above.											
22a. SIGNATURE		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		22e. REC'D BY REGISTRAR		22f. REGISTRAR'S SIGNATURE	
M.B. Queen		9 Feb 1962		M.B. QUEEN		7112 Willow Ave Takoma Park, Md		FEB 13 '62		Arthur S. Thane	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		(State)			
Cremation		2-9-62		Lee's Crematorium		Washington D.C.					
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Lee Funeral Home Wash D.C.				FEB 13 '62		Arthur S. Thane					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
02072		Item 220, Film G300 3/1/62 iwk				02054			
1. PLACE OF DEATH a. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Rhode Island				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural)					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pawtucket				
c. LENGTH OF STAY IN lb 25 Days					d. STREET ADDRESS 70 Armistice Blvd				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. Naval Hospital, Bethesda, Maryland					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) JOHN BROWN					4. DATE OF DEATH February 21 19 62				
5. SEX Male					6. COLOR OR RACE Caucasian				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 28 Feb 1917				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Officer					9. AGE (In years last birthday) 44 yrs.				
10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country) Penna				
13. FATHER'S NAME Hawthorne Howland					12. CITIZEN OF WHAT COUNTRY? USA				
14. MOTHER'S MAIDEN NAME Elizabeth Brown					15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes				
16. SOCIAL SECURITY NO. 263 60 7265					17. INFORMANT Mrs. Diana Howland (Wife) same as #2				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.3 Acute - leukemia - Lymphocytic DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 months									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19									
20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1310									
20f. (City or town) (County) (State)									
21. I certify that (this hospital) attended the deceased from 27 January, 1962, to 21 February 1962, and that death occurred on 21 February 1962, at 1310 P.M. and that death occurred on the causes and on the date stated above.									
22a. SIGNATURE Charles E. Brodine									
22b. DATE SIGNED									
22c. PHYSICIAN'S NAME (Type) Charles E. BRODINE, LTCDR MC USN									
22d. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL									
23b. DATE THEREOF 2/26/62									
23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMATORY									
23d. LOCATION (City, town or county) (State) ARLINGTON VIRGINIA									
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers									
ADDRESS WASHINGTON, D.C.									
25a. REC'D BY REGISTRAR DATE FEB 26 '62									
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus									

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U.S. Naval Hospital, Bethesda, Maryland  
February 21, 1945  
Dear Sir:  
Enclosed for you are two copies of a letterhead memorandum (LHM) dated and captioned as above.  
Very truly yours,  
W. W. Chambers, Major, MC, USA  
Director, Naval Hospital, Bethesda, Maryland  
Enclosure



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02073						02055					
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>26 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				d. STREET ADDRESS <b>125 Granville Avenue</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>						a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Robert Vance Hull</b>			First Middle Last			4. DATE OF DEATH <b>February 24, 1962</b>			Month Day Year		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 5, 1905</b>		9. AGE (In years last birthday) <b>56 yrs.</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Naval Officer</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Sherman Tecumseh Hull</b>				14. MOTHER'S MAIDEN NAME <b>Mary Hempt</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Annapolis, Md.</b> <b>Wife Elizabeth Hull, 125 Granville Ave.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>157X</b> IMMEDIATE CAUSE (a) <b>Adenocarcinoma of pancreas</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Jan. 30, 1962</b> , to <b>Feb. 24, 1962</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Feb. 24, 1962</b> , and that death occurred at <b>9:15 AM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>William P. Baker</b>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <b>February 24, 1962</b>		
22c. PHYSICIAN'S NAME (Type) <b>WILLIAM P. BAKER, LT MC USN</b>						22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-27-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Naval Academy Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Annapolis, Maryland</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>John Taylor Funeral Home</b>						ADDRESS <b>Annapolis, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 28 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02074						02056					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY Montgomery						a. STATE MARYLAND					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BETHESDA						b. COUNTY Montgomery					
c. LENGTH OF STAY IN 1b 7 days						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER Spring					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SUBURBAN Hospital						d. STREET ADDRESS 814 PHILADELPHIA					
3. NAME OF DECEASED (Type or print) JOHN FRANKLIN HURDLE						4. DATE OF DEATH 22 19 62					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/19/88		9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter						11. BIRTHPLACE (County & State, or foreign country) WASH D.C.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOHN FRANKLIN HURDLE						14. MOTHER'S MAIDEN NAME ALICE A. Byles					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None						16. SOCIAL SECURITY NO. 578-01-0786			17. INFORMANT Mr. Wilbur T. Hurdle 814 Philadelphia Ave, S.S. Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: 150 X DUE TO CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last, (b) ACUTE ANURIA (c) CARCINOMA OF ESOPHAGUS LOWER 1/3RD MONTHS WITH METASTASES										INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)
21. I certify that (I) (his hospital) attended the deceased from 10:30 to Feb 22, 1962, that (I) (me) last saw the deceased alive on 22 21 1962 and that death occurred at M, from the causes and on the date stated above.											
22a. SIGNATURE Dewitt E. DeLauter						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 2-22-62		
22c. PHYSICIAN'S NAME (Type) DEWITT E. DELAUTER						22d. ADDRESS 8025 ABERDEEN RD. BETH. MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 2-24-62		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery			23d. LOCATION (City, town or county) Prince Georges Co. Maryland			(State)
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc. Silver Spring, Md.						25. REC'D BY REGISTRAR FEB 26 '62			25b. REGISTRAR'S SIGNATURE Warner E. Pumphrey		

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02075

## CERTIFICATE OF DEATH

02057

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Dawsonville, Md</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Boyd's, Md</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Ada</u> Middle <u>Virginia</u> Last <u>Jackson</u>			<b>4. DATE OF DEATH</b> Month <u>Feb</u> Day <u>15</u> Year <u>1962</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (Country & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>James Mason</u>		14. MOTHER'S MAIDEN NAME <u>May ?</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr Daniel T. Jackson</u> (Same as item #2) Address	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct, Acute.</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arterio sclerotic Cardiovascular Disease</u> DUE TO (c) <u>years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11:30 AM 15 Feb, 1962</u> to <u>12:45 PM 15 Feb, 1962</u> that (I) ( <del>we</del> ) last saw the deceased alive on <u>15 Feb 1962</u> , and that death occurred at <u>12:45 PM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>Robert L. Snowden</u>		M.D.		22b. DATE SIGNED <u>15</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>Boyd's, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>2/19/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rocky Hill Cem.</u>	
23d. LOCATION (City, town or county)		23e. (State)		23f. (Country)	
<u>Burial</u>		<u>Clarksburg, Md</u>		<u>Rockville, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		ADDRESS <u>Rockville, Md</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 21 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>					

08032

CERTIFICATE OF DEATH

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DATE OF DEATH

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Attest: I, the undersigned, being a duly qualified and authorized officer of the State of New York, do hereby certify that the foregoing is a true and correct copy of the original record of the death of the person named therein, as the same appears from the records of the State of New York.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02076

02058

<b>1. PLACE OF DEATH</b> a. COUNTY <i>Montgomery</i> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If Institution: Residence before admission) e. STATE <i>Washington</i> D.C. b. COUNTY <i>D.C.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>	
c. LENGTH OF STAY IN 1b <i>2-22-60</i>		d. STREET ADDRESS <i>4550 Conn. Ave</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Althea Woodland</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <i>ALICE</i> Middle <i>ESTELLE</i> Last <i>JAMES</i>		<b>4. DATE OF DEATH</b> Month <i>Feb.</i> Day <i>15</i> Year <i>1962</i>	
<b>5. SEX</b> <i>F</i>	<b>6. COLOR OR RACE</b> <i>Cauc-</i>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <i>March 13-1875</i>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>Own home</i>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <i>Washington DC</i>
<b>13. FATHER'S NAME</b> <i>Dr. James R. Reilly</i>		<b>14. MOTHER'S MAIDEN NAME</b> <i>Alice Pywell</i>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <i>No</i>		<b>16. SOCIAL SECURITY NO.</b> <i>NONE</i>	
<b>17. INFORMANT</b> <i>Hospital records- 1000 Indiana St.</i>		Address	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> DUE TO (b) <i>Influenza-Viral Infection</i> DUE TO (c) <i>Arterial Sclerotic Heart disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Terminal 1 1/2 wks.</i>	
2De. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <i>a.m.</i> <i>19</i> p.m.	2Dd. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	2Df. (City or town) (County) (State)
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <i>1959</i> <b>to</b> <i>Feb. 15, 1962</i> <b>that (I) (we) last saw the deceased alive on</b> <i>Feb. 14, 1962</i> <b>and that death occurred at</b> <i>8:30 P.</i> <b>from the causes and on the date stated above.</b>			
22e. SIGNATURE <i>Robert A. Hare</i> M.D.		22b. DATE SIGNED <i>Feb 15 1962</i>	
22c. PHYSICIAN'S NAME (Type) <i>Robert A. Hare MD</i>		22d. ADDRESS <i>7600 Carroll Ave Tak. Pk. Md.</i>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <i>Burial</i>		<b>23b. DATE THEREOF</b> <i>2-19-62</i>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <i>Rock Creek Cemetery</i>
		<b>23d. LOCATION</b> (City, town or county) (State) <i>Washington, D. C.</i>	
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <i>Raymond A. Z...</i>		<b>25a. REC'D BY REGISTRAR</b> <i>Feb 21 '62</i>	
<b>Warner E. Pumphrey, Inc. Silver Spring, Md.</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Hume</i>	

05058

05058

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Washington, D. C.

Room 1200, Green Building

2-10-61

Dear Sir:

1000 2nd Street, N.W.

Warner E. Humphrey, Inc., Silver Spring, Md.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02059

02077

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN 1b <u>2 1/2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SUBURBAN Hospital</u>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>North Carolina</u> b. COUNTY <u>Orange</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chapel Hill</u> d. STREET ADDRESS <u>Glenn Heights Hurst Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <u>ROLF JOHANNESSEN</u>			<b>4. DATE OF DEATH</b> Last <u>2</u> Month <u>26</u> Day <u>19</u> Year <u>62</u>		
<b>5. SEX</b> <u>MALE</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
<b>8. DATE OF BIRTH</b> <u>7-1-94</u>		<b>9. AGE</b> (In years last birthday) <u>67</u>		<b>10. IF UNDER 1 YEAR</b> Months <u>7</u> Days <u>25</u>	
<b>11. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		<b>12. KIND OF BUSINESS OR INDUSTRY</b> <u>Professor</u>		<b>13. BIRTHPLACE</b> (County & State, or foreign country) <u>SKien NORWAY</u>	
<b>14. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A Since 1918</u>		<b>15. FATHER'S NAME</b> <u>HARTVIG JOHANNESSEN</u>		<b>16. MOTHER'S MAIDEN NAME</b> <u>MAJA LARSEN</u>	
<b>17. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> <u>W.W.T.</u>		<b>18. SOCIAL SECURITY NO.</b> <u>Wife - SAME AS ABOVE</u>		<b>19. INFORMANT</b> <u>2d</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute hemorrhagic enteritis, cause?</u> (b) <u>571.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL MEDICAL CONDITION GIVEN IN PART I (a) <u>Atherosclerotic heart disease</u>					
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b>		<b>20g. (County)</b>		<b>20h. (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>2/23 1962</u> <b>to</b> <u>2/26 1962</u> <b>that (I) (we) last saw the deceased alive on</b> <u>2/26 1962</u> <b>and that death occurred at</b> <u>11 A.M.</u> <b>from the causes and on the date stated above.</b>					
<b>22a. SIGNATURE</b> <u>Marvin Wadler</u> M.D.		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>2/26/62</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>MARVIN WADLER</u>		<b>22d. ADDRESS</b> <u>8218 Wisconsin Ave. Bethesda, Md</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Cremation 2/27/62</u>		<b>23b. DATE THEREOF</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill Crematory</u>	
<b>23d. LOCATION (City, town or county)</b> <u>Suitland, Maryland</u>		<b>23e. (State)</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey</u>		<b>ADDRESS</b> <u>Bethesda, Maryland</u>		<b>25a. REC'D BY REGISTRAR</b> <u>DATE MAR 1 '62</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Kraus</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
02078				CERTIFICATE OF DEATH				02060							
Item 23b Film G308 3/9/62 mb															
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Harrisburg</b> ✓									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>74 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harrisburg</b> <b>75X-3</b>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. NAVAL HOSPITAL</b>						d. STREET ADDRESS <b>505 Wiconisco, Apt. #3</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Arthur</b> Middle <b>Fritchhoff</b> Last <b>Johnson</b>						4. DATE OF DEATH <b>February 28 19 62</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 1, 1898</b>		9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Marine Corps Officer</b>						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Massachusetts</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>Alex Johnson</b>						14. MOTHER'S MAIDEN NAME <b>Ellen Nelson</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes</b>						16. SOCIAL SECURITY NO.						17. INFORMANT Address <b>Wife: Mrs. Mary G. Johnson, Same as #2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>157X</b> IMMEDIATE CAUSE (a) <b>Adenocarcinoma of pancreas with wide spread metastasis</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Dec. 16, 19 62 to Feb. 28, 19 62</b>		(County) <b>4:40AM</b>		(State)					
21. I certify that <b>he</b> (this hospital) attended the deceased from <b>Dec. 16, 19 62</b> to <b>Feb. 28, 19 62</b> that <b>he</b> (we) last saw the deceased alive on <b>Feb. 28, 19 62</b> , and that death occurred at <b>4:40AM</b> from the causes and on the date stated above.															
22a. SIGNATURE <b>John R. Warmolts MD.</b>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>February 28, 1962</b>							
22c. PHYSICIAN'S NAME (Type) <b>JOHN R. WARMOLTS LT MC USN</b>						22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Mar. 5, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>		23d. LOCATION (City, town or county) <b>Gettysburg, Pa.</b>		(State)							
24. FUNERAL DIRECTOR'S SIGNATURE <b>Bender Funeral Home</b>						ADDRESS <b>Gettysburg, Pa.</b>		25a. REC'D BY REGISTRAR <b>MAR 5 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. K...</b>					

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RECEIVED (1941)

U.S. MAIL NO. 10

STATION

CONNECTION

MAILING ORDER

JOHNSON

ALICE

JOHN A. JOHNSON

Wife: Mary Jane A. Johnson, born 1901

and connection of persons with the same.

JOHNSON, MARY JANE A.

U.S. MAIL NO. 10

CONNECTION

MAILING ORDER



1  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

02079

02061

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WASHINGTON, D. C.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WHEATON</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON, D. C.</b> 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WHEATON NURSING HOME</b>				d. STREET ADDRESS <b>5008 5TH ST. N. W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>NEVIN BENJAMIN JOHNSON</b>				4. DATE OF DEATH Month Day Year <b>2 16th 1962</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAU.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/16/1900</b>		9. AGE (In years last birthday) <b>61</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GEOLOGICAL SURVEY</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>WILLIAM B. JOHNSON</b>				14. MOTHER'S MAIDEN NAME <b>ETTA THOMAS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO <b>305X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Alzheimer's disease, brain</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes mellitus</b> INTERVAL BETWEEN ONSET AND DEATH <b>terminal about 6 months</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 15, 1961</b> to <b>date</b> 19 <b>1961</b> , that (I) (we) last saw the deceased alive on <b>2-15-62</b> 19 <b>1962</b> , and that death occurred at <b>12:55</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>S. G. Anagnos, M.D.</b>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>S. GEORGE ANAGNOS</b>				22d. ADDRESS <b>1150 CONNECTICUT AVE. N.W. D.C.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>2-2-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenwood</b>		23d. LOCATION (City, town, or county) (State) <b>Rockville Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. K. [Signature]</b>				25a. REC'D BY REGISTRAR <b>FEB 19 1962</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. [Signature]</b>	

02041

CERTIFICATE OF DEATH

92028



WASHINGTON, D. C.

JANUARY 2, 1900

2000 21st St. N. W.

DECEASED

22/10/1900

22/10/1900

22/10/1900

*Alzheimer's disease*  
*Paralytic*

*Diabetes mellitus*

22/10/1900

22/10/1900

22/10/1900

*Alzheimer's disease*  
*Paralytic*  
*Diabetes mellitus*



08080

08080

M

Grace Anne Joyce  
Female white  
House wife  
16 years old  
1924

10 P 20 11

Rev. Mr. Brown

1924

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

<div>1</div> <div> <div>02081</div> <div>02063</div> </div>										
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>35 Kensington</b> d. STREET ADDRESS <b>4005 Halsey St</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <b>Aretta M Judd</b>					<b>4. DATE OF DEATH</b> Month <b>February</b> Day <b>19</b> Year <b>19 62</b>					
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>12/17/27</b>		<b>9. AGE</b> (In years last birthday) <b>34</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Virginia</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		
<b>13. FATHER'S NAME</b> <b>Howard Racey</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>Procene Kamer</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>				<b>16. SOCIAL SECURITY NO.</b> <b>213-22-2342</b>		<b>17. INFORMANT</b> <b>husband Donald A. Judd</b>		<b>Address</b> <b>same as above</b>		
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Pneumothorax</b> DUE TO (b) <b>Generalized Tetanus</b> (c) <b>undifferentiated sarcoma of Left Thigh</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 days</b>		
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>										
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)						
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. <b>19</b>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <b>Feb 12</b> , 19 <b>62</b> to <b>Feb 19</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>Feb 18</b> , 19 <b>62</b> , and that death occurred at <b>4:15 PM</b> , from the causes and on the date stated above.										
<b>22a. SIGNATURE</b> <b>Michael R. Doda, M.D.</b>					<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>			<b>22b. DATE SIGNED</b>		
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Michael R. Doda, M.D.</b>					<b>22d. ADDRESS</b> <b>10620 Georgia Ave. Silver Spring, Md.</b>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>burial</b>			<b>23b. DATE THEREOF</b> <b>2/22/62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Cedar Hill Cemetery</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Suitland, Md.</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>The S H Thomas Co 2901-14th St N.W. D.C.</b>					<b>ADDRESS</b>		<b>25a. REC'D BY REGISTRAR</b> <b>FEB 21 1962</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Thomas</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02082

02064

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN b <b>2 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b> d. STREET ADDRESS <b>1505 South Columbus Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Bessie Marie Keller</b>		4. DATE OF DEATH Month <b>February</b> Day <b>20</b> Year <b>19 62</b>		9. AGE (In years last birthday) <b>10</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Oklahoma</b>			
13. FATHER'S NAME <b>Robert Keller</b>		14. MOTHER'S MAIDEN NAME <b>Bessie Caldwell</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>7540</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Post operative hemorrhage</b> DUE TO (c) <b>Congenital heart disease, Tetralogy of Fallot</b> INTERVAL BETWEEN ONSET AND DEATH <b>25 minutes</b> <b>4 hours</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>February 18, 19 62 to February 20, 19 62</b>			
20f. (City or town) <b>8:10 PM</b>		20g. (County) <b>8:10 PM</b>		20h. (State) <b>8:10 PM</b>			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>February 18, 19 62</b> to <b>February 20, 19 62</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>February 20, 19 62</b> , and that death occurred at <b>8:10 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>A. G. Morrow, M.D.</b>		22b. DATE SIGNED <b>February 21, 1962</b>		22c. PHYSICIAN'S NAME (Type) <b>A. G. Morrow</b>			
22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>		22e. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>					
23a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/23/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>			
23d. LOCATION (City, town or county) <b>Arlington Va.</b>		23e. REC'D BY REGISTRAR <b>W.W. Chamber Co. 3072 M St NW</b>		23f. REGISTRAR'S SIGNATURE <b>W.W. Chamber Co. 3072 M St NW</b>			
23g. DATE <b>FEB 23 '62</b>		23h. REGISTRAR'S SIGNATURE <b>William S. Kraus</b>					

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(M)

Robert Keller  
The Clinical Center, Bethesda, Md.  
1505 South Columbia Street  
Arlington, Virginia  
U.S.A.

U.S.A.  
Arlington, Virginia  
The Clinical Center, Bethesda, Md.  
1505 South Columbia Street  
Arlington, Virginia  
U.S.A.

January 30, 1968  
January 30, 1968

U.S.A.  
Arlington, Virginia  
The Clinical Center, Bethesda, Md.  
1505 South Columbia Street  
Arlington, Virginia  
U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
02083									
02065									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			d. STREET ADDRESS <b>9104 Hempstead Ave.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>9104 Hempstead Ave.</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <b>JOHN</b>		Middle <b>J.</b>		Last <b>KELLEY</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>8,</b> Year <b>19 62</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 22, 1901</b>		9. AGE (In years last birthday) <b>60</b> yrs. <b>11</b> Months <b>16</b> Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrical Engineer- U. S. Govt.</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Penna</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>John Joseph Kelley</b>					14. MOTHER'S MAIDEN NAME <b>Nellie Finnegan</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Wife</b> <b>Kathryn C. Kelley</b>		Address <b>Same as Item 2.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertension Arteriosclerosis &amp; Chronic Heart Disease &amp; Myocardial Infarction</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Infarction</b> (b) <b>Infarction</b> (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Bethesda</b>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/26, 1961</b> to <b>2/8/62</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>2/8/1962</b> , and that death occurred at <b>2P</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>W. T. Joyce, M.D.</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE <b>Feb. 9/62</b>		
22c. PHYSICIAN'S NAME (Type) <b>W. T. Joyce, M.D.</b>					22d. ADDRESS <b>8106 Maple Ridge Road, Bethesda, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/13/1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town or county) (State) <b>Arlington Virginia</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey Bethesda, Maryland</b>					25a. REC'D BY REGISTRAR <b>DATE FEB 13 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		

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Montgomery

Montgomery

Bethesda

Bethesda

9104 Hampstead Ave.

9104 Hampstead Ave.

JOHN

KELLEY

Feb. 8, 62

White

Feb. 22, 1901

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Electrical Engineer, U. S. Govt.

Perma

John Joseph Kelley

Nellie Finnegan

WW II

Kathryn C. Kelley

Yes

Same as item 2.

John, M.D.

Arlington National

Arlington National

Robert A. Thompson, Bethesda, Maryland

Feb. 9/62

8108 Maple Ridge Road, Bethesda, Md.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>30 Silver Spring</b>	
		d. STREET ADDRESS <b>10010 Sidney Rd</b>	
3. NAME OF DECEASED (Type or print) First <b>Samuel</b> Middle <b>Lee</b> Last <b>Kemp</b>		4. DATE OF DEATH Month <b>February</b> Day <b>12</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 27 1907</b>
9. AGE (In years last birthday) <b>54 yrs.</b>		IF UNDER 1 YEAR Months <b>54</b> Days <b>27</b> Hours <b>00</b> Min. <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Edward Kemp</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Day</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>no</b>	
17. INFORMANT <b>Stanley Kemp</b>		Address <b>same as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute myocardial insufficiency</b> <b>450.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute coronary occlusion</b> DUE TO (c) <b>Hemorrhage into myocardiadial plaque</b>			INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>II</b> <b>II</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DATE SIGNED <b>Feb. 12, 1962</b>	
		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb, 15 1962</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak</b>	22d. LOCATION (City, town, or country) (State) <b>Gaithersburg Md.</b>
23. FUNERAL DIRECTOR <b>Francis H. Barber</b>		ADDRESS <b>Laytonsville, Md.</b>	
24a. REC'D BY REGISTRAR <b>FEB 15 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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Laytonville, La.

Forest, La. 1902

University

La.



VR A15 (4)  
15M 7/61

1. PLACE OF DEATH e. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN H <b>30 Years</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6307 Bells Mill Rd.</b>					
3. NAME OF DECEASED (Type or print) <b>BLANCH</b>		First <b>L.</b>		Middle <b>KERWIN</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF DEATH <b>Feb. 19 62</b>		9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		12. KIND OF BUSINESS OR INDUSTRY		13. BIRTHPLACE (County & State, or foreign country) <b>Iowa</b>	
14. FATHER'S NAME <b>Joseph Lytle</b>		15. MOTHER'S MAIDEN NAME <b>Adaline Hall</b>		16. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		18. SOCIAL SECURITY NO. <b>None</b>		19. INFORMANT <b>Charles Kerwin-Husband-same 2d</b>	
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>411X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Aortic Stenosis</b> (c) <b>Rheumatic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b> <b>20 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		22. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
23. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		24. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
26. (City or town) <b>Bethesda</b>		27. (County) <b>Montgomery</b>		28. (State) <b>Md.</b>	
29. I certify that (I) (this hospital) attended the deceased from <b>Feb 18 1962</b> to <b>Feb 19 1962</b> that (I) (we) last saw the deceased alive on <b>Feb 18 1962</b> and that death occurred at <b>11:30 A.M.</b> from the causes and on the date stated above.					
30. SIGNATURE <b>William H. Killay</b>		31. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. <b>Feb. 19, 1962</b>		32. DATE SIGNED <b>Feb. 19, 1962</b>	
33. PHYSICIAN'S NAME (Type) <b>WILLIAM H. KILLAY</b>		34. ADDRESS <b>8218 Wisconsin Ave., Bethesda, Md.</b>			
35. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		36. DATE THEREOF <b>2/23/62</b>		37. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat. Cem.</b>	
38. LOCATION (City, town or county) <b>Arlington, Virginia</b>		39. (State) <b>Virginia</b>			
40. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		41. ADDRESS <b>Bethesda, Maryland</b>		42. REC'D BY REGISTRAR <b>Feb 23 '62</b>	
43. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>		44. DATE <b>Feb 23 '62</b>			

02082

Montgomery

Bethesda

5507 Bell's Mill Rd.

BRANCH

Female White

Housewife

Joseph Lyke

No

None

Adeline Hall

Charles Kevin-Husband- same 50

X

Feb. 19, 1962

3218 Wisconsin Ave., Bethesda, Md.

WILLIAM H. ALLEN

Surgeon

8/23/62

Atkinson Rd., Arlington, Virginia

Robert A. Thompson, Bethesda, Maryland

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02086

## CERTIFICATE OF DEATH

02068

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>89 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>1908 Florida Avenue, N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <b>Texas (None) Ketchum</b>		<b>4. DATE OF DEATH</b> Month <b>February 14</b> Day <b>19</b> Year <b>62</b>		<b>5. SEX</b> <b>Female</b>							
<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>July 21, 1892</b>							
<b>9. AGE</b> (In years last birthday) <b>69</b> yrs. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Asst. Mgr. Apt. House</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Texas</b>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.										
Months	Days										
Hours	Min.										
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>James Sentell</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Frances Matthew</b>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>579-22-1440</b>		<b>17. INFORMANT</b> <b>The Medical Record The Clinical Center, Bethesda 14, Maryland</b>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%;"> <tr> <td style="width: 30%;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <b>Hepatocellular liver damage and jaundice</b>  <b>171X</b> </td> <td style="width: 70%;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <b>2 months</b> </td> </tr> <tr> <td> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>  <b>(b) Small bowel-perineal fistula</b> </td> <td> <b>2 months</b> </td> </tr> <tr> <td> <b>(c) Recurrent carcinoma of cervix</b> </td> <td> <b>14 years</b> </td> </tr> </table>						<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Hepatocellular liver damage and jaundice</b> <b>171X</b>	<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 months</b>	<b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(b) Small bowel-perineal fistula</b>	<b>2 months</b>	<b>(c) Recurrent carcinoma of cervix</b>	<b>14 years</b>
<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Hepatocellular liver damage and jaundice</b> <b>171X</b>	<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 months</b>										
<b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(b) Small bowel-perineal fistula</b>	<b>2 months</b>										
<b>(c) Recurrent carcinoma of cervix</b>	<b>14 years</b>										
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Hour <b>e.m.</b> <b>19</b> <b>p.m.</b>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> <b>Not While</b> <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)							
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>							
<b>21. I certify that</b> <input checked="" type="checkbox"/> <b>(this hospital)</b> <b>attended the deceased from</b> <b>November 17, 1961</b> <b>to</b> <b>February 14, 1962</b> <b>that</b> <input checked="" type="checkbox"/> <b>(we) last saw the deceased alive on</b> <b>February 14, 1962</b> , <b>and that death occurred at</b> <b>11:20 PM</b> , <b>from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <b>J. Kent Trinkle</b>		<b>22b. DATE SIGNED</b> <b>2/15/62</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>J. Kent Trinkle, M.D.</b>							
<b>22d. ADDRESS</b> <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>		<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>									
<b>23b. DATE THEREOF</b> <b>19 FEB. 1962</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>ARLINGTON NATIONAL</b>		<b>23d. LOCATION (City, town or county)</b> <b>ARLINGTON VA.</b>							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Russell Funeral Home</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE FEB 16 '62</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Thomas</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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05068

(M)

Ministry of Columbia

Ministry of Columbia

Washington

89 years

Bedford

1908 London Avenue, N.W.

The Clinical Center, Bethesda, Md., Md.

February 1962

Bedford

(None)

Texas

July 21, 1962

X

Female

D.S.S.

Texas

Real Estate

Anal. M.T. House

Frances Jackson

James Bentley

The Medical Record

279-22-1110 The Clinical Center, Bethesda, Md., Maryland

Ho

2 months

hepatocellular liver damage and jaundice

2 months

Small bowel-peritoneal fistula

10 years

Recurrent carcinoma of cervix

X

November 1961 February 1962

11:30 PM

2/18/62

X

The Clinical Center, National  
Institute of Health, Bethesda, Md., Md.

February 1962

*J. Kent Ertel*

J. Kent Ertel, M.D.

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1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02087

02069

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> <i>St. Mary's</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>9 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Parker</b> Last <b>Kienle</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>14</b> Year <b>1962</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/14/90</b>		9. AGE (In years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>District transit</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William G. Kienle</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Medley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>578-10-5428</b>		17. INFORMANT <b>Laura K. Kienle</b> Address <b>12,903 Parkland Dr. Rockville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of liver &amp; metastases</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2/5/1962</b> to <b>2/14/1962</b> , that (I) (we) last saw the deceased alive on <b>2/13/1962</b> , and that death occurred at <b>2 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <i>W. T. Joyce</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>William T. Joyce, M. D.</b>				22d. ADDRESS <b>8106 Maple Ridge Rd. Bethesda 14, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-17-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Silver Spring Montgomery Co. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond A. Pumphrey</i> <b>Warner E. Pumphrey, Inc. Silver Spring, Md.</b>				25a. REC'D BY REGISTRAR <b>FEB 19 '62</b>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Pumphrey</i>	

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02088

02070

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> <b>47X-3</b>	
c. LENGTH OF STAY IN lb <b>23 days</b>		d. STREET ADDRESS <b>3024 Tilden Street NW</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Cyrus Baker Kitchen</b>		4. DATE OF DEATH Month <b>February</b> Day <b>15</b> Year <b>19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <b>Dec. 24, 1893</b>	9. AGE (In years last birthday) <b>68</b> yrs. IF UNDER 1 YEAR Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min. <b>68</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Naval Officer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>New York</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Cyrus B. Kitchen</b>		14. MOTHER'S MAIDEN NAME <b>Ellie L. French</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I, WW II</b>		17. INFORMANT Address <b>Wife: Mrs. Dickey K. Kitchen, Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease with Myocardial Infarction</b> <b>4-20-00</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Jan. 22, 1962</b> , to <b>Feb. 15, 1962</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Feb. 15, 1962</b> , and that death occurred at <b>1:45 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Howard A. Pearson</b> M.D.		22b. DATE SIGNED <b>February 15, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>HOWARD A. PEARSON LCDR MC USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-19-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		25a. REC'D BY REGISTRAR <b>Feb 19 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>			

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HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02089 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02071

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Damascus</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Damascus</u>	
c. LENGTH OF STAY IN 1b <u>5 yr</u>		d. STREET ADDRESS <u>Pleasant Plain Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Pleasant Plain Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert Lee Knight</u>		4. DATE OF DEATH <u>2-4-1962</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-21-1926</u>	
9. AGE (In years last birthday) <u>36</u> yrs.		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sgt. Md. State Police</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Mo., St. Louis</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Henry Knight</u>		14. MOTHER'S MAIDEN NAME <u>Mary Helen Weimeister</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>219-18-9307</u>	
17. INFORMANT <u>Mrs Jacquelyn P. Knight, Item 2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thoracic hemorrhage</u> DUE TO (b) <u>bullet wound thru left chest (heart)</u> DUE TO (c) <u></u>			
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), (b), (c), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted 32 cal bullet wound</u>	
20c. TIME OF INJURY Month, Day, Year <u>10:15 a.m. 2-4-1962</u>		20d. INJURY OCCURRED While <input type="checkbox"/> No While <input checked="" type="checkbox"/> at work <input type="checkbox"/> el work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) <u>Damascus</u> (County) <u>Montg</u> (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>2-4-62</u>	
Address (Street, city, town, or county)		22a. REC'D BY REGISTRAR	
22b. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 7, 1962</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge</u>		22d. LOCATION (City, town, or country) <u>Elkridge, Md.</u>	
23. FUNERAL DIRECTOR <u>Chin L. Wolsworth</u>		ADDRESS <u>Damascus, Md.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thayer</u>	
DATE <u>FEB 8 '62</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Very Warm Welcome

William Henry Keegan

1910-1911 Mrs. Margaret T. Keegan, 1910

1910

1910-1911 Mrs. Margaret T. Keegan, 1910

1910-1911

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02090

02072

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY in 1b <u>2 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Althea Woodland Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>District of Columbia</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON, D.C.</u> d. STREET ADDRESS <u>1315 Iris St. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>-</u> Last <u>KRUEGER</u>		4. DATE OF DEATH Month <u>February</u> Day <u>21</u> Year <u>1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 14, 1882</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>14</u>	IF UNDER 24 HRS. Hours <u>14</u> Min. <u>3</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE MAID</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>GERMANY</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>HENRY KRUEGER</u>	
14. MOTHER'S MAIDEN NAME <u>ANNA KRUEGER</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>086-26-2140</u>		17. INFORMANT <u>Hospital Records</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal obstruction</u> DUE TO <u>153.8</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adenocarcinoma of colon.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>OCT 1960</u> to <u>2.1.2062</u> , that (I) <u>(no)</u> last saw the deceased alive on <u>20.2062</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Samuel T. Kimble</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>SERUCH T. KIMBLE</u>		22d. ADDRESS <u>927 Pennington Ave., Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>23 FEB. 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>FOREST LAWN CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>BUFFALO, N.Y.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ronald L. Lenzel Anne</u>		25a. REC'D BY REGISTRAR <u>FEB 23 '62</u>	
ADDRESS <u>1400 Longview Ave.</u>		25b. REGISTRAR'S SIGNATURE <u>Orlando L. Kenna</u>	

(M)

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05075

Henry Krueger  
Silver Spring 2 days  
District of Columbia  
Washington, D.C.  
1115 1st St. N.W.  
X

Elisabeth - Krueger  
February 21  
F W  
Only 11/11/11

Henry Krueger  
Hans  
Germany  
Krueger  
W.S.

Handwritten notes and signatures at the bottom of the page, including "Krueger" and "Henry Krueger".



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

<div style="text-align: center;"> <b>1</b> <span style="float: right;">02092</span> </div> <div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div> <div style="text-align: right;"> <b>02074</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> c. LENGTH OF STAY in lb <u>2 1/2 yrs.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> d. STREET ADDRESS <u>1300 Floral Street N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>GEORGE C. LAMBROS</u>				<b>4. DATE OF DEATH</b> Month <u>FEB.</u> Day <u>28</u> Year <u>1962</u>				<b>5. SEX</b> <u>M</u> <b>6. COLOR OR RACE</b> <u>W</u> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>2/28/87</u> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>9. AGE</b> (In years last birthday) <u>75</u> <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired owner Show Boat Restaurant</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Boat Restaurant</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>GREECE</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>				<b>13. FATHER'S NAME</b> <u>Christos Lambros</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Aspasia Papanoreou</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> <b>16. SOCIAL SECURITY NO.</b> <u>?</u> <b>17. INFORMANT</b> <u>Harry Lambros</u> <b>Address</b> <u>same as #2</u>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO (b) <u>ESSENTIAL HYPERTENSION</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>CHRONIC PROSTATITIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>							
<b>20c. TIME OF INJURY</b> Hour <u>  </u> e.m. <u>  </u> p.m. <u>  </u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u> <b>20f. (City or town)</b> <u>  </u> <b>(County)</b> <u>  </u> <b>(State)</b> <u>  </u>				<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>AUG. 14, 1937</u> <b>to</b> <u>FEB. 28, 1962</u> <b>that (I) (we) last saw the deceased alive on</b> <u>FEB. 28, 1962</u> <b>and that death occurred at</b> <u>12:45 M.</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Henry M. Lowden</u> <b>22b. DATE SIGNED</b> <u>2/28/62</u>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>				<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Henry M. Lowden</u>			
<b>22d. ADDRESS</b> <u>5206 NORWAY DR. CHEVY CHASE, MD</u>				<b>23a. REC'D BY REGISTRAR</b> <u>  </u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Hines</u>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>burial</u> <b>23b. DATE THEREOF</b> <u>3/2/62</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Glenwood Cemetery</u> <b>23d. LOCATION</b> (City, town or county) <u>Washington, D.C.</u> <b>(State)</b> <u>  </u>				<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>The S.H. Hines Company</u> <b>ADDRESS</b> <u>2901 14th St. N.W. Washington 9, D.C.</u> <b>DATE</b> <u>2/62</u>							

MEDICAL CERTIFICATION

05051

05052

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*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words are difficult to decipher but appear to include:]*

*General Hall*  
*Secretary*  
*Chairman*  
*Members*  
*Committee*  
*Report*  
*Findings*  
*Recommendations*  
*Conclusions*  
*Summary*  
*Appendix*  
*References*  
*Notes*  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02093

Items 23 Film G308 3/2/62 ink

02076

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN lb <b>14 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>North Carolina</b> b. COUNTY <b>Clayton</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Route #2</b> d. STREET ADDRESS <b>70X-3</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>First Fab Middle Goldes Last Lee</b>			4. DATE OF DEATH Month <b>February</b> Day <b>22</b> Year <b>1962</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>December 12, 1901</b>		9. AGE (In years last birthday) <b>60 yrs.</b>		IF UNDER 1 YEAR Months <b>5</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Agricultural</b>		
11. BIRTHPLACE (County & State, or foreign country) <b>North Carolina</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Haff Lee</b>			14. MOTHER'S MAIDEN NAME <b>Cora Watson</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>738-56-5507</b>		
17. INFORMANT <b>The Medical Record</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Myelocytic Leukemia</b> DUE TO (c) <b>5 months</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>204.3</b>		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) <b>Smithfield</b>			20g. (County) <b>N.C.</b>		
20h. (State) <b>N.C.</b>			21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>February 8, 1962</b> to <b>February 22, 1962</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>February 22, 1962</b> , and that death occurred at <b>7:00 PM</b> , from the causes and on the date stated above.		
22a. SIGNATURE <b>Robert H. Levin</b> 22c. PHYSICIAN'S NAME (Type) <b>Robert H. Levin, M.D.</b>			22b. DATE SIGNED <b>February 23, 1962</b> 22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>			23b. DATE THEREOF <b>2/24/62</b>		
23c. NAME OF CEMETERY OR CREMATORY <b>Shazier's Funeral Home Inc. 389-R.2 Ave. N.W.</b>			23d. LOCATION (City, town or county) <b>Smithfield, N.C.</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Shazier's Funeral Home Inc. 389-R.2 Ave. N.W.</b>			25a. REC'D BY REGISTRAR <b>DATE FEB 27 '62</b>		
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>					

021010

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North Carolina

January 12, 1900

January 12, 1900

January 12, 1900

The National Center, Bethesda, Md.

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1900-1901 The National Center, Bethesda, Md.

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1900-1901 The National Center, Bethesda, Md.

January 12, 1900

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1900-1901 The National Center, Bethesda, Md.



121  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02094  
02077  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>20 hrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>11021 Dobbins Drive</u>			
3. NAME OF DECEASED (Type or print) <u>Virginia Mae Lee</u>				4. DATE OF DEATH <u>Feb 15 1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 3 1892</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR <u>15</u> Months <u>15</u> Days		IF UNDER 24 HRS. <u>1962</u> Hours <u>15</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>			
13. FATHER'S NAME <u>Raymond Butler Ferguson</u>				14. MOTHER'S MAIDEN NAME <u>Mollie Tabor</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>579-12-7316</u>			
17. INFORMANT <u>Carl E. Lee (Son)</u>				Address <u>same as above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCT</u> DUE TO <u>ARTERIOSCLEROTIC HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4200</u> DUE TO (c) <u>2 days 4 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>DIABETES MELLITUS</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/14/62</u> , 19 <u>62</u> , to <u>2/15/62</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>2/15/62</u> , 19 <u>62</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Henry C. Scruggs</u> M.D.				22b. DATE SIGNED <u>2/15/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>Henry C. Scruggs</u>				22d. ADDRESS <u>7720 Wisconsin Ave. Beth. Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/19/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR <u>FEB 21 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

<b>1. PLACE OF DEATH</b> a. COUNTY <i>Montgomery</i> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> c. LENGTH OF STAY IN 1b <i>7 yrs</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>1602 Noyes Dr</i>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Montg</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>28 Silver Spring</i> d. STREET ADDRESS <i>1602 Noyes Dr</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <i>Minnie W. Lippe</i>		<b>4. DATE OF DEATH</b> Month <i>Feb</i> Day <i>12</i> Year <i>1962</i>		<b>5. SEX</b> <i>Female</i> <b>6. COLOR OR RACE</b> <i>white</i> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <i>3-9-1875</i> <b>9. AGE</b> (in years last birthday) <i>86</i> yrs. <b>IF UNDER 1 YEAR</b> Months <i>86</i> Days <i>86</i> <b>IF UNDER 24 HRS.</b> Hours <i>86</i> Min. <i>86</i>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>housewife</i> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>AT HOME</i> <b>11. BIRTHPLACE</b> (State or foreign country) <i>Ill</i> <b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U.S.A.</i>		<b>13. FATHER'S NAME</b> <i>Henry Wittland</i> <b>14. MOTHER'S MAIDEN NAME</b> <i>Caroline Schreiner</i>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <i>NO</i> <b>16. SOCIAL SECURITY NO.</b> <i>NONE</i> <b>17. INFORMANT</b> <i>Edna Brown (sister)</i> Address <i>Item 2</i>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Cornary occlusion</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i>				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <i>19</i> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)			
<b>21. I certify</b> that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <i>Frank J. Broschant</i> M.D. <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DATE SIGNED</b> <i>Feb 12-62</i>		<b>EXAMINER'S NAME</b> (Type) <i>FRANK J. Broschant</i> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>Quincy Ill</i>					
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <i>BURIAL</i> <b>22b. DATE THEREOF</b> <i>2/17/1962</i> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <i>GREENMOUNT CEM</i> <b>22d. LOCATION</b> (City, town, or country) (State) <i>Quincy Ill</i>		<b>23. FUNERAL DIRECTOR</b> ADDRESS <i>W.W. CHAMBERS, INC. SILVER SPRING, MD</i> <b>24a. REC'D BY REGISTRAR</b> <i>FEB 19 '62</i> <b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur L. Kneiss</i>					

85058

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
02096											
02079											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>						c. LENGTH OF STAY in lb <b>8 1/2 hours</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital,</b>						e. STREET ADDRESS <b>8500 New Hampshire Ave.</b>					
3. NAME OF DECEASED (Type or print) <b>Kathryne Gant Lofland</b>						4. DATE OF DEATH <b>February 23, 19 62</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 26, 1919</b>		9. AGE (In years last birthday) <b>42 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>			
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Palmer Morrow</b>				14. MOTHER'S MAIDEN NAME <b>Fay Gant</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give number and date of service)				17. INFORMANT <b>BOYD L. LOFLAND 8500 NEW HAMPSHIRE AVE</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema, acute</b> DUE TO (b) <b>Pending toxicology studies</b> DUE TO (c) <b>Acute Salicylism</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Reported - drinking alcoholic beverages daily for unknown number of days. Stated to have been taken aspirin &amp; librium</b>											
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County)				20h. (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE <b>Frank J. Broschert</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>FRANK J. BROSCHE</b>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DATE SIGNED <b>Feb 24 1962</b>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
Address (Street, city, town, or county)						Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>2/27/62</b>				22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL CEMETARY</b>			
22d. LOCATION (City, town, or country) <b>ARLINGTON, VIRGINIA</b>				22e. REC'D BY REGISTRAR <b>FEB 28 '62</b>				22f. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			
23. FUNERAL DIRECTOR <b>WARNER E PUMPHREY</b>											
ADDRESS <b>434 GEORGIA AVE, SILVER SPRINGS MARYLAND</b>											

MEDICAL CERTIFICATION

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25.19



TO HOSPITAL  
be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

ATTENDING PHYSICIAN:

The law requires that the death certificate be executed within 24 hours after death.

1

Coroner notified and approved

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02097					02080						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)						
a. COUNTY <b>Montgomery</b>					a. STATE <b>Maryland</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					b. COUNTY <b>Montgomery</b>						
<b>Kensington</b>					<b>39 Silver Spring</b>						
c. LENGTH OF STAY IN lb					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
<b>3 days</b>					<b>1</b>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS						
<b>Kensington Gardens Nursing Home</b>					<b>2206 Prichard Road</b>						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year		
<b>Lillie</b>			<b>(nmi)</b>			<b>Lohman</b>			<b>February 16 1962</b>		
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
<b>female</b>		<b>white</b>				<b>Dec. 20, 1877</b>		<b>84 yrs.</b>		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
<b>Housewife</b>				<b>Own home</b>				<b>St. Louis, Missouri</b>			
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<b>U.S.A.</b>				<b>Frederick Reiffeiss</b>				<b>Catherine Geimer</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Address			
<b>No</b>				<b>None</b>				<b>Mrs. Lillie L. Cleaver 2306 Blueridge Ave. S.S. Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										<b>12 HRS</b>	
<b>Cerebral Embolus</b>											
332X DUE TO											
Conditions, if any, which gave rise to immediate cause (b)										<b>36 HRS</b>	
<b>Saddle Thrombus - Aorta &amp; Iliac</b>											
(c), stating the underlying cause last.										<b>10 YRS</b>	
<b>Generalized Arteriosclerosis</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>Fractured Right Femur 1/23/62 Pinned 1/29/62</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m. p.m. 19				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from 2/14/62 to 2/16/62, 1962, that (I) (we) last saw the deceased alive on 2/15/62, 1962, and that death occurred at 9:55 AM, from the causes and on the date stated above.											
22a. SIGNATURE						22b. DATE SIGNED					
<b>Horace H. Custis Jr</b>						<b>2/16/62</b>					
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
<b>HORACE H. CUSTIS JR</b>						<b>1852 Columbia Rd NW WASH</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)		
<b>Burial</b>			<b>2-21-62</b>			<b>Parklawn Cemetery</b>			<b>St. Louis, Missouri</b>		
24. FUNERAL DIRECTOR'S SIGNATURE						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<b>Raymond A. Glick</b>						<b>DATE FEB 21 '62</b>		<b>Charles E. Hana</b>			
<b>Warner E. Pumphrey, Inc. Silver Spring, Md.</b>											

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(117)

3

1. *Chlorophyll a* and *Chlorophyll b* were determined by the method of Arar and Collins (1971).

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02098

## CERTIFICATE OF DEATH

02081

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery County</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>4 WEEKS</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac Bethesda</u> d. STREET ADDRESS <u>9550 RIVER ROAD DRIVE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>MARY JACOBS LOHR</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>FEBRUARY 12 1962</u> Month Day Year			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>JAN 4 1875</u>	
<b>9. AGE</b> (In years last birthday) <u>88</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>OWN HOME</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>MADISON County, VA.</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>United States</u>							
<b>13. FATHER'S NAME</b> <u>Henry Judson Wallace</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>UNKNOWN Alice COPPAGE</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>				<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>		<b>17. INFORMANT</b> <u>Mrs. Charles E. Wilson</u> Address <u>9550 RIVER RD Bethesda, MD.</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331 X</u> DUE TO <u>CIRCULATORY COLLAPSE</u> (b) <u>CEREBRAL VASCULAR ACCIDENT</u> (c) <u>GEN'L ARTERIO SCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HYPER PYREXIA (107°)</u>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>D.N.A.</u>			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. 19		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>16 JAN 1962</u> <b>to</b> <u>12 FEB 62</u> <b>that (I) (we) last saw the deceased alive on</b> <u>2/11 1962</u> <b>and that death occurred</b> <u>11:45 AM</u> <b>from the causes and on the date stated above</b>							
<b>22a. SIGNATURE</b> <u>Charles J. Savarese, Jr.</u> M.D.				<b>22b. DATE SIGNED</b> <u>2/10/62</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>CHARLES J. SAVARESE, JR.</u>	
<b>22d. ADDRESS</b> <u>4890 BATTERY LANE</u>				<u>BETHESDA MD.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>2-14-62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Graham Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Orange Virginia</u>	
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <u>Raymond E. Pumphrey, Inc.</u> Address <u>8434 Georgia Ave. Silver Spring, Md.</u>				<b>25a. REC'D BY REGISTRAR</b> <u>FEB 15 '62</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kline</u>	

(M)

05083

05081

Female White  
Mary Jacobs  
2280 R. 1st St. N. W.  
Washington, D. C.

Female White  
Janet 1875-82  
2280 R. 1st St. N. W.  
Washington, D. C.

Female White  
Mary Jacobs  
2280 R. 1st St. N. W.  
Washington, D. C.

Female White  
Janet 1875-82  
2280 R. 1st St. N. W.  
Washington, D. C.

MARY JACOBS  
(1875-82)

05083

Female White  
Janet 1875-82  
2280 R. 1st St. N. W.  
Washington, D. C.

Female White  
Mary Jacobs  
2280 R. 1st St. N. W.  
Washington, D. C.

Wm. L. Humphrey, Inc. Silver Spring, Md.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME  
SM 9/60

FOR STATE  
HEALTH DEPT.

M

75

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2

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02082											
02099											
1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Wheaton Hills d. STREET ADDRESS 11803 Grandview Ave							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b 14 hours				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium and Hospital											
3. NAME OF DECEASED (Type or print) Ella NMN Lund				4. DATE OF DEATH February 4 1962							
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 11, 1882 79 yrs.		9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN JOHNSON				14. MOTHER'S MAIDEN NAME MARIE UNKNOWN							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO.				17. INFORMANT Washington Sanitarium and Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 465X Bilateral pulmonary embolism DUE TO (b) Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Diabetes mellitus 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall from bed in Hosp-							
20c. TIME OF INJURY Month, Day, Year ? 2-X 1962				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) Takoma Pk. Md		(County) Montg	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Frank J. Broschant				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED Feb 4 1962			
EXAMINER'S NAME (Type) FRANK J. Broschant				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 2-7-62		22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		22d. LOCATION (City, town, or country) (State) SUITLAND, MARYLAND			
23. FUNERAL DIRECTOR Real Funeral Home				ADDRESS 4812 90 Wash. D.C.				24a. REC'D BY REGISTRAR DATE FEB 9 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Turner	



02092

02092



W. J. Johnson

W. J. Johnson





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME  
5M 9/60

MEDICAL CERTIFICATION

<div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>02100</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>02083</div> </div>											
1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN 1b <u>3 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>627 Marcia Lane</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>md</u> b. COUNTY <u>montg</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>627 Marcia Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Veronica Mann</u>						4. DATE OF DEATH <u>Feb 3 1962</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-3-1926</u>		9. AGE (In years last birthday) <u>41</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michael Charles</u>						14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)						17. INFORMANT <u>Jos. Mann (husband)</u> Address <u>Stuen 2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> DUE TO (b) <u>Chronic myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Valvular heart disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broschan</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>FRANK J. Broschan</u>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transit</u>						22b. DATE THEREOF <u>2/4/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Nicholas</u>		22d. LOCATION (City, town, or country) (State) <u>Brownsville, Pennsylvania</u>	
23. FUNERAL DIRECTOR <u>Iyson Wheeler</u> ADDRESS <u>Funeral Home-1331 E. Montg. Ave. Rockville, Md.</u>						24a. REC'D BY REGISTRAR <u>FEB 7 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

(M)

(I)

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03080

PLANNED TO RECONSTRUCT THE FACILITY

M

W. J. [illegible]

W. J. [illegible]

W. J. [illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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M  
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02101  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
02084

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>34 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>North Carolina</b> b. COUNTY <b>Swannanoa</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Route # 1</b> d. STREET ADDRESS <b>70X-3</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Thomas Joseph Marett</b>		4. DATE OF DEATH Month <b>February</b> Day <b>11</b> Year <b>19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 15, 1892</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanical Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Engineering</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Benjamin I. Marett</b>		14. MOTHER'S MAIDEN NAME <b>Mary Lou Reese</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unascertainable</b>	
17. INFORMANT <b>The Medical Record</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Malignant Carcinoid</b> DUE TO (c) <b>Hypertensive Cardiovascular Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>17 9X</b>	
19. INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from <b>January 8, 1962</b> to <b>February 11, 1962</b> that (H) (we) last saw the deceased alive on <b>February 11, 1962</b> , and that death occurred at <b>9:25 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Michael Field</b>		22b. DATE SIGNED <b>February 12, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Michael Field</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit 2/13/62</b>		23b. DATE THEREOF <b>2/13/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Black Mt. Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Black Mountain, N. C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>FEB 14 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Haines</b>			

(M)

February 11, 1962

Bedford

14 days

Swannanoa

The Clinical Center, Bethesda, Md., Md.

Route 1

x

Thomas

Joseph

Harold

February 11

62

White

May 15, 1962

62

Technical Director

Investigating

Georgia

U.S.A.

Benjamin I. Harbo

Henry Lee Jones

The National Academy

Transmittable The Clinical Center, Bethesda, Md., Maryland

30

Outpatient Clinic

The Great Circuit

Representative of the American

January 8, 1962 February 11, 1962

February 11, 1962

*Handwritten signature*

to the light

The Clinical Center, National  
Institute of Health, Bethesda, Md., Md.

Bureau of Transmittal 2/13/62 Black Mt. Cemetery Black Mountain, N. C.

Robert A. Pumphrey, Bethesda, Maryland

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02102

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02085

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. LENGTH OF STAY IN 1b <u>D.O.A.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SUBURBAN</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>SHENA LASHAY MARSHALL</u>				4. DATE OF DEATH <u>FEB. 13 19 62</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 14 1961</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <u>3</u> yrs. Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min.		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>ERNEST MARSHALL</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				14. MOTHER'S MAIDEN NAME <u>NANCY LARMAN</u>			
16. SOCIAL SECURITY NO. <u>NOTHER SAME AS ABOVE</u>				17. INFORMANT <u>NANCY LARMAN</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> 475X DUE TO (b) <u>Upper respiratory infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>Found cold in bed</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Brochart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROCHART</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE OF BURIAL <u>Feb 15/62</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Forest OAK Cemetery</u>				22d. LOCATION (City, town, or country) (State) <u>Gaithersburg, Maryland</u>			
23. FUNERAL DIRECTOR <u>William C. Hilton</u>				24a. REC'D BY REGISTRAR <u>Barneville</u>			
24b. REGISTRAR'S SIGNATURE <u>William C. Hilton</u>				DATE <u>FEB 19 1962</u>			

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FOR STATE  
HEALTH DEPT.

Item 206 Form 308 3-5-62 ans  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**02103 MEDICAL EXAMINER'S CERTIFICATE OF DEATH** **02086**

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>✓</b>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY in 1b <b>D.O.A.</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington</b> <b>478-3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hospital</b>			d. STREET ADDRESS <b>3800 14th. Street, N.W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Marie</b> Middle <b>Louise</b> Last <b>Martin</b>			4. DATE OF DEATH Month <b>February</b> Day <b>21</b> Year <b>19 62</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/22/04</b>	9. AGE (in years last birthday) <b>57 yrs.</b>	IF UNDER 1 YEAR Months <b>57</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Paris, France</b>	
12. CITIZEN OF WHAT COUNTRY? <b>France</b>			13. FATHER'S NAME <b>Louis Chaume Chaume</b>		
14. MOTHER'S MAIDEN NAME <b>Jeanne Martin Treny</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>		
16. SOCIAL SECURITY NO. <b>Yes</b>			17. INFORMANT <b>Denise Heilmann, 12104 Livingstone St.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Internal hemorrhage</b> DUE TO <b>704.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rupture of heart, liver &amp; spleen</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Found lying on basement floor</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Found lying on basement floor</b>			
20c. TIME OF INJURY Month, Day, Year <b>12:29 p.m. 2-21 1962</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home of deceased</b>		20f. (City or town) (County) (State) <b>Wheaton Montgomery Md</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Frank J. Broschant</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>2-22-62</b>	
EXAMINER'S NAME (Type) <b>FRANK J. Broschant</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <b>12106 Livingston St Wheaton Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-26-62</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Montgomery County Maryland</b>	
23. FUNERAL DIRECTOR <b>Warner E. Humphrey, Inc.</b>		ADDRESS <b>8434 Georgia Ave Silver Spring, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 26 '62</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles S. Kenna</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																	
02104						02087											
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)											
a. COUNTY <b>Montgomery</b>						a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Germantown</b>											
c. LENGTH OF STAY IN 1b <b>33 days</b>						d. STREET ADDRESS <b>Rt. #2</b>											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year								
<b>Robert</b>			<b>C.</b>			<b>Martin</b>			<b>February 2, 1962</b>								
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/10/05</b>		9. AGE (In years last birthday) <b>57 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>								
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>						13. FATHER'S NAME <b>Robt. MARTIN</b>											
14. MOTHER'S MAIDEN NAME <b>LUCY BARKER</b>						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>NO</b>											
16. SOCIAL SECURITY NO.						17. INFORMANT <b>Wife - Ethel Martin</b>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Acute Myocardial Infarction</b> (c) <b>Arteriosclerosis</b> DUE TO cause listed.																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		Month, Day, Year <b>1-6</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Rockville, Md.</b>		(County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>1-6</b> , 19 <b>62</b> to <b>2-2</b> , 19 <b>62</b> that (H) (we) last saw the deceased alive on <b>2-2</b> , 19 <b>62</b> and that death occurred at <b>8:55 A.M.</b> from the causes and on the date stated above.																	
22a. SIGNATURE <b>P.P. Andrews</b>						M.D.			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <b>2-2-62</b>					
22c. PHYSICIAN'S NAME (Type) <b>P.P. ANDREWS</b>						22d. ADDRESS <b>M.D. WASHINGTON D.C.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town or county) (State)					
<b>Burial</b>				<b>2/6/62</b>				<b>Lincoln Park.</b>				<b>Rockville, Md.</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b>						ADDRESS <b>Rockville Md.</b>						25a. REC'D BY REGISTRAR DATE <b>FEB 7 '62</b>			25b. REGISTRAR'S SIGNATURE <b>Wm. L. Thomas</b>		

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02105

02088

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Montgomery</b></span>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>45</b> <b>Bethesda</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hospital</b>				d. STREET ADDRESS <b>9835 Singleton Drive</b>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Velma W Matthews</b>				<b>4. DATE OF DEATH</b> <b>Feb. 19 19 62</b>			
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Sept. 22, 1892</b>	
<b>9. AGE</b> (In years last birthday) <b>69</b> yrs.		<b>IF UNDER 1 YEAR</b> Months <b>4</b> Days <b>27</b>		<b>IF UNDER 24 HRS.</b> Hours <b>19</b> Min. <b>62</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> -----		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Kansas</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>							
<b>13. FATHER'S NAME</b> <b>Jonothan Wright</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Laura A. Wilson</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>				<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> <b>Mrs. William Olson-Daughter-same 2d</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> DUE TO (b) <b>URETERAL OBSTRUCTION</b> DUE TO (c) <b>CARCINOMA OF RECTUM WITH METASTASES</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>HYPERTENSIVE VASCULAR DISEASE</b>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Hour <b>e.m.</b> <b>19</b> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>7/12</b> , 19 <b>61</b> , to <b>2/19</b> , 19 <b>62</b> that (I) ( <del>we</del> ) last saw the deceased alive on <b>2/19</b> , 19 <b>62</b> , and that death occurred at <b>3:00</b> M, from the causes and on the date stated above.							
<b>22e. SIGNATURE</b> <b>John H. Tuohy</b>				<b>22b. DATE SIGNED</b> <b>2/19</b>		<b>22d. ADDRESS</b> <b>7720 WISCONSIN AVE BETHESDA 14, MD.</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>JOHN H. TUOHY, M.D.</b>				<b>22f. ADDRESS</b> <b>7720 WISCONSIN AVE BETHESDA 14, MD.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial-Transit 2/20/62</b>		<b>23b. DATE THEREOF</b> <b>2/20/62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Memorial Lawn Cem.</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Wichita, Kansas</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Robert A. Pumphrey, Bethesda, Maryland</b>				<b>25a. REC'D BY REGISTRAR</b> <b>FEB 23 '62</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.  
VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02106

Items 4 & 23 Film G508 5/7/62 iwk

CERTIFICATE OF DEATH

02089

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY in 1b <b>7 1/2 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>48 Chevy Chase</b>	
3. NAME OF DECEASED (Type or print) First <b>Otis</b> Middle <b>F.</b> Last <b>Mays</b>		4. DATE OF DEATH Month <b>February</b> Day <b>27</b> Year <b>19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/10/75</b>
9. AGE (In years last birthday) <b>86 yrs.</b>		10. IF UNDER 1 YEAR Months <b>86</b> Days <b>86</b> Hours <b>86</b> Min. <b>86</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		11b. KIND OF BUSINESS OR INDUSTRY	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. BIRTHPLACE (County & State, or foreign country) <b>Oregon</b>	
14. FATHER'S NAME <b>Benton Mays</b>		15. MOTHER'S MAIDEN NAME <b>Elizabeth Parker</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		17. SOCIAL SECURITY NO. <b>?</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident.</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Uremia. (Pt. had metastatic Carcinoma of glans penis.)</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
21c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
23e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		24f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>Feb 27, 1962</b> to <b>Feb 27, 1962</b> , that (I) (we) last saw the deceased alive on <b>Feb 27, 1962</b> , and that death occurred at <b>48 Chevy Chase</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>George A. Gray, Jr.</b> M.D.		22b. ADDRESS <b>4140 Chevy Chase Dr.</b>	
22c. PHYSICIAN'S NAME (Type) <b>George A. GRAY, JR., MD</b>		22d. ADDRESS <b>4140 Chevy Chase Dr.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 1, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert Humphrey</b>		25. REC'D BY REGISTRAR <b>DATE MAR 2 '62</b>	
25a. REGISTRAR'S SIGNATURE <b>Arthur S. Knease</b>		25b. REGISTRAR'S SIGNATURE	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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02107 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02090

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr Georges</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Delphi</u>	
c. LENGTH OF STAY IN 1b <u>D.O.A</u>		d. STREET ADDRESS <u>10506 Powder Mill Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASH SAINT Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Jane PARKS</u>		4. DATE OF DEATH <u>2-3-1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-21-57</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		9. AGE (In years last birthday) <u>4</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Robert E Mc Lowell</u>	
14. MOTHER'S MAIDEN NAME <u>Worothy Gill</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Robert Mc Lowell</u> Address <u>Same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE HEMORRHAGIC PNEUMONIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>ACUTE INTERSTITIAL VIRAL PNEUMONITIS</u> (c), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ACUTE CEREBRAL EDEMA</u>		INTERVAL BETWEEN ONSET AND DEATH days days	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
22. CHIEF MEDICAL EXAMINER <u>Frank J. Bluschart</u> M.D.		23. DATE SIGNED <u>Feb 4 1962</u>	
24. DEPUTY MEDICAL EXAMINER <u>FRANK J. BLUSCHART</u> Address (Street, city, town, or county)		25. REC'D BY REGISTRAR <u>FEB 6 '62</u>	
26. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>		27. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	
28. DATE THEREOF <u>2/4/62</u>		29. NAME OF CEMETERY OR CREMATORY <u>Steele Creek</u>	
30. LOCATION (City, town, or country) (State) <u>Charlotte, N. C.</u>		31. FUNERAL DIRECTOR <u>The S.H. Hines Co. 2801 - 14th St. N.W. Wash 9, D.C.</u>	

MEDICAL CERTIFICATION

08090

08100

M

Received 2/1/68  
Charles, N. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02091

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>82 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <b>North Carolina</b> <span style="float: right;">b. COUNTY <input checked="" type="checkbox"/></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marion</b> d. STREET ADDRESS <b>P.O. Box 809</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <b>Frankie Jean McGee</b>				<b>4. DATE OF DEATH</b> <b>February 24, 19 62</b> Month Day Year							
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>October 17, 1953</b>		<b>9. AGE</b> (In years last birthday) <b>8 yrs.</b> IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Student</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>None</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>North Carolina</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>John McGee</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Rena Thomas</b>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>				<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> <b>The Medical Records</b> <b>The Clinical Center, Bethesda 14, Maryland</b>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>Wilm's Tumor, Metastatic to liver, pelvis, subdiaphragmatic regions.</b> IMMEDIATE CAUSE (a) <b>180X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Post-operative absence of left kidney and spleen</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Post-operative absence of left kidney and spleen</b>										INTERVAL BETWEEN ONSET AND DEATH <b>15 Months</b>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20c. TIME OF INJURY</b> Hour a.m. <b>19</b> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> <b>Marion</b> (County) <b>North Carolina</b> (State)					
<b>21. I certify that (I) (this hospital) attended the deceased from December 4, 1962 to February 24, 1962, that (I) (we) last saw the deceased alive on February 24, 1962, and that death occurred at 7:15AM from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <i>Edward S. Henderson</i> M.D. <b>22c. PHYSICIAN'S NAME (Type)</b> <b>Edward S. Henderson, M.D.</b>						<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/> <b>2-24-62</b> <b>22d. ADDRESS</b> <b>The Clinical Center, National Institutes Of Health, Bethesda, 14, Md.</b>		<b>22b. DATE SIGNED</b>			
<b>23b. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial-transit 2-24-62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Oak Grove Cemetery</b>		<b>23d. LOCATION</b> (City, town or county) <b>Marion, North Carolina</b> (State)							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>ROBERT A. PUMPHREY</b> <b>Bethesda, Md.</b>				<b>25a. REC'D BY REGISTRAR</b> <b>DATE MAR 1 '62</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Kline</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60

100501

North Carolina

Winston

100501

John

October 1, 1953

North Carolina

Winston

The Clinical Center, Bethesda, Md.

The Clinical Center, Bethesda, Md.

with a tumor, removed to liver, and

pathological findings.

Post-operative findings of liver and spleen

Post-operative findings of liver and spleen

December 1, 1953

100501

February 2, 1954

2-2-54

The Clinical Center, National

Institute of Health, Bethesda, Md.

Winston, North Carolina

One year

100501-2-2-54

ROBERT A. BURNETT, M.D.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02109

02092

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. LENGTH OF STAY IN 1b <u>30 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Sanitarium</u>				d. STREET ADDRESS <u>2032 Belmont Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Jean</u> Middle <u>Curtice</u> Last <u>McGoodwin</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>22</u> Year <u>1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 27, 1884</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min. <u>77</u>		IF UNDER 24 HRS. Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min. <u>77</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Missouri</u>			
11. BIRTHPLACE (State or foreign country) <u>Missouri</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Charles E. Curtice</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Heaton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT <u>Preston McGoodwin-Hato Ray, Puerto Rico</u>				Address <u>Rio</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Cancer from Adenocarcinoma of Rectum</u> DUE TO <u>(Reported &amp; Sustained June 1958)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>generalized metastasis</u> DUE TO <u>Carcinoma of Rectum</u> (b) <u>3 yrs.</u> (c) <u>3 yrs.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Genital disorders &amp; Central Fertilization</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>1/25/62</u> 19 <u>62</u> to <u>2/22/62</u> 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>2/22/62</u> and that death occurred at <u>6:50 P</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Sam Allen</u> M.D. <u>Kensington, Maryland</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>2/22/62</u>							
22c. PHYSICIAN'S NAME (Type) <u>Sam Allen</u> 22d. ADDRESS <u>10,407 Fawcett Kensington</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/26/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. News Co. Wash, D. C.</u>				25a. REC'D BY REGISTRAR <u>FEB 26 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. House</u>	

03030

DEPARTMENT OF HEALTH

03106

(M)

1900-1901

1900-1901

1900-1901

1900-1901

1900-1901

1900-1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
02110					02093									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)									
a. COUNTY <b>Montgomery</b>					a. STATE <b>Maryland</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>					b. COUNTY <b>Montgomery</b>									
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>48 Bethesda</b>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>7005 Clarendon Road</b>					d. STREET ADDRESS <b>7005 Clarendon Road</b>									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED					4. DATE OF DEATH									
(Type or print) <b>Leslie David Measell</b>					Month <b>Feb</b> Day <b>12</b> Year <b>19 62</b>									
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)						
<b>Male</b>		<b>White</b>		<b>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></b>		<b>11/1/86</b>		<b>75 yrs.</b>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?					
<b>Broker</b>			<b>Real Estate</b>			<b>Maryland</b>			<b>US</b>					
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME									
<b>Leslie D. Measell, Sr.</b>					<b>Fannie Gernand</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT				
<b>No</b>					<b>Yes</b>					<b>Unknown</b>				
					<b>Calvin R. Measell-son, Kensington, Md.</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										<b>4-20-1/2 hour</b>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										<b>2 hour</b>				
DUE TO (b) <b>Acute Congestive Heart Failure</b>										<b>2 hour</b>				
DUE TO (c) <b>Coronary sclerosis and Hypertension</b>										<b>20 years</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED?				
<b>Diabetes mellitus and Angina pectoris</b>										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
19														
21. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>Jan 28</b> , 19 <b>61</b> , to <b>Feb 12</b> , 19 <b>62</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>Feb 12</b> , 19 <b>62</b> , and that death occurred at <b>1:45</b> M, from the causes and on the date stated above.														
22a. SIGNATURE <b>R. Stephen Hulbert</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED <b>Feb 12/1962</b>				
22c. PHYSICIAN'S NAME (Type) <b>R. Stephen Hulbert</b>					22d. ADDRESS <b>3000 Dent Place NW</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)					
<b>Burial-Transit</b>			<b>2/15/62</b>			<b>Mt. Olivet Cemetery</b>			<b>Portsmouth, Virginia</b>					
24 FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>					ADDRESS					25a. REC'D BY REGISTRAR				
										25b. REGISTRAR'S SIGNATURE <b>Calvin R. Measell</b>				
					DATE <b>FEB 14 '62</b>									

02110

02093

(M)

Montgomery

Maryland

Montgomery

Bechtel

Bechtel

7005 Clarendon Road

7005 Clarendon Road

62

62

Feb

Messell

David

Leah

11/1/86

11/1/86

11/1/86

White

Male

11

Maryland

Real Estate

Busby

Lane's Ground

Leah D. Messell, Jr.

Unknown Calvin R. Messell-son, Kensington, Md.

No

(1)

Robert A. Murphy, Bethesda, Maryland

Robert A. Murphy, Bethesda, Maryland

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02111 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02094

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>DC.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY in 1b <u>7 wks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u>		d. STREET ADDRESS <u>1474 Columbia Rd N.W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Althea Woodland Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Marie</u> Middle <u>Rachel</u> Last <u>Meeker</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>8</u> Year <u>1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-2-1881</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>U-S-A</u>	
13. FATHER'S NAME <u>Wm W. Whelock</u>				14. MOTHER'S MAIDEN NAME <u>Rachel Ann Roche</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>				16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Nursing Home Record</u> Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary occlusion</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>2-8-62</u>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/12/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR ADDRESS <u>The S. H. Hines Co. Washington, D. C.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 13 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

14450

14450

14450



THE 2. B. HENRY CO. BOSTON, MASS. 02111



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02112

CERTIFICATE OF DEATH

Reg. Dist. No. 02095

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X CHEVY CHASE VIEW, KENSINGTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILHELMINA</u> Middle <u>O.</u> Last <u>MEITZLER</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>19</u> Year <u>1962</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 2, 1870</u>
9. AGE (In years last birthday) <u>92</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON DC.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>STEPHEN HELLMUTH</u>		14. MOTHER'S MAIDEN NAME <u>PAULINE BUEHL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>PAULINE M. MEITZLER</u>		Address <u>See 2D</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Congestive Heart disease</u> DUE TO <u>Coronary arterio-sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO <u>15 yrs</u> (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>2 yrs</u> <u>15 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour _____ a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 15</u> , 19 <u>40</u> , to <u>FEB 19</u> , 19 <u>62</u> that I last saw the deceased alive on <u>FEB 16</u> , 19 <u>62</u> , and that death occurred at <u>5P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles Harnsberger</u> M.D.		ADDRESS (Street, city or town, state) <u>4201 NEW HAMPSHIRE AVE NW</u> DATE SIGNED <u>2/19/62</u>	
PHYSICIAN'S NAME (Type) <u>CHAS. W. HARNSEBERGER</u>		<u>WASHINGTON D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>FEB 22, 1962</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR Hill CEMETRY</u>	22d. LOCATION (City, town, or county) (State) <u>SUITLAND, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Anlon</u>		ADDRESS <u>4148 WISC. AVE NW</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 23 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02113

02096

1. PLACE OF DEATH e. COUNTY <b>Montgomery County</b>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				c. LENGTH OF STAY IN 1b <b>1647-2</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Belmont Nursing Home</b> <b>17220 Colesville, Road, SS, Md.</b>				d. STREET ADDRESS <b>3201 Arundel Road</b>			
3. NAME OF DECEASED (Type or print) <b>BYRD ALBERT MOORE</b>				4. DATE OF DEATH Month Day Year <b>February 6, 19 62.</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 6, 1878</b>	
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Franklin Cty. Ronoke, Va. U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>23-118-5371</b>			
17. INFORMANT <b>Mr. Aleph H. Wood, 3812 Kearney Rd. Manor</b>				Address <b>17000 Colmar</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Cerebral atherosclerosis</b> (c) <b>Generalized atherosclerosis</b> causing the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>5 days</b> <b>sev'l yrs.</b> <b>sev'l yrs.</b>				INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>sev'l yrs.</b> <b>sev'l yrs.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1/27/1962</b> to <b>3/6/1962</b> that (I) (we) last saw the deceased alive on <b>1/27/1962</b> and that death occurred at <b>6 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Donald Nelson</b>				22b. DATE SIGNED <b>2/6/62</b>		22c. PHYSICIAN'S NAME (Type) <b>DONALD NELSON, M.D.</b>	
22d. ADDRESS <b>10620 Georgia Ave., Silver Spring, Md.</b>							
23a. BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 9, 1962</b>		23c. NAME OF CEMETERY <b>Fort Lincoln Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Bladensburg, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. CHAMBERS CO. Riverdale, Md.</b>				25a. REC'D BY REGISTRAR <b>FEB 9 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



1911

1911

Montgomery County

Maryland

Prince Georges

Silver Spring

Mount Rainier

Baltimore Home  
17220 Coleville, Road, 22, Md.

3201 Arundel Road

BYRD

ALBERT

MOORE

February 6,

62.

June 6, 1878

Male White

Carpenter

Building

Franklin City, Honolulu, Va. U.S.A.

Unknown

Unknown

No None

27-11-571 Mr. Albert F. Wood, 2812 Kennedy Rd. Manot, Md.

General information  
General information  
General information

2 days  
2nd yr  
2nd yr

Donald Nelson

DONALD NELSON, N.D.

XXXXXX

Feb. 9, 1962 Fort Lincoln Cemetery, Elkhartsville, Maryland

W. W. CHAMBERS CO. Riverdale, Md.

1/11/62

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

02114

02097

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Wash., D.C.</b> b. COUNTY <b>--</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>				c. LENGTH OF STAY IN 1b <b>11 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47X-3</b>	
d. NAME OF HOSPITAL (If hospital, give street address) OR INSTITUTION <b>11901 Georgia Avenue Wheaton Nursing Home</b>				d. STREET ADDRESS <b>4301 Mass. Ave. N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Isabelle</b> Middle <b>Morache</b> Last <b>Morache</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>11</b> Year <b>1962</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 2, 1871</b>	
9. AGE (In years last birthday) <b>90</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>9</b> Hours <b></b> Min. <b></b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b></b>		11. BIRTHPLACE (State or foreign country) <b>New York City</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Alfred Archambault</b>				14. MOTHER'S MAIDEN NAME <b>Emma Dessereau</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b></b>				16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Daughter</b> Address <b>Mrs Frank Stemple 4301 Mass. Ave N.W.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary Thrombosis</b> DUE TO (b) <b>Branchio-Pneumonia</b> DUE TO (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>6 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Thrombo-Phlebitis of Inferior Vena Cava</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 4, 1962</b> to <b>Feb. 11, 1962</b> that (I) (we) last saw the deceased alive on <b>2/10</b> 19 <b>62</b> and that death occurred at <b>8:30</b> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <b>Samuel Dessoff</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>SAMUEL DESSOFF</b>				22d. ADDRESS <b>1302-188th N.W. Wash. D.C.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/14/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Catherines Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Moscow Pa.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Sims Co. 2901 14th St. N.W.</b>				25a. REC'D BY REGISTRAR <b>DATE FEB 13 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	



050015

CENTRAL INTELLIGENCE AGENCY

05114



TO : DIRECTOR, CENTRAL INTELLIGENCE AGENCY  
FROM : [Illegible]  
SUBJECT : [Illegible]  
[The following text is extremely faint and largely illegible, appearing to be a memorandum or report body.]





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with this State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02115

## CERTIFICATE OF DEATH

02098

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Potomac (rural)</b> c. LENGTH OF STAY IN 1b <b>Potomac (rural)</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Potomac Manor</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>59 8609 Burdette Road</b> d. STREET ADDRESS <b>1 Bethesda, Maryland</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>David L Morgal</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>17</b> Year <b>19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 31, 1874</b>
9. AGE (In years last birthday) <b>87 yrs.</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>16</b> Hours <b></b> Min. <b></b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gardner-Golf Club</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Gardening</b>	
12. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		13. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14. FATHER'S NAME <b>John Morgal</b>		15. MOTHER'S MAIDEN NAME <b>Martha (Unknown)</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>Unknown</b>	
18. INFORMANT <b>Ralph L. Morgal-Son-Cabin John, Md.</b>		19. ADDRESS <b></b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiration Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchopneumonia</b> DUE TO (c) <b>General Atherosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b> <b>24 hr</b> <b>20 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Atherosclerosis Heart L</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 17, 1962</b> to <b>Feb 18, 1962</b> , that (I) (we) last saw the deceased alive on <b>Feb 17, 1962</b> , and that death occurred at <b>8 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>W H Killay</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>W H Killay</b>		22d. ADDRESS <b>8218 Wisconsin Ave Bethesda</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/21/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Potomac Church Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Potomac, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>FEB 23 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>			

VR A15 (4)  
15M 9/60

02093

02115



Montgomery

Poland (first)

Poland (second)

David

White

Carthage-Gold Club

John Norton

no

Martin (unknown)

Unknown with E. Norton-Son-Cabin Norton, W.

Robert A. Humphrey, Bethesda, Maryland  
Robert A. Humphrey, Bethesda, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02099

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>10 Rockville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hospital</b>		d. STREET ADDRESS <b>25 Wall St., R</b>	
3. NAME OF DECEASED (Type or print) <b>L. CURTIS</b> First Middle Last		4. DATE OF DEATH <b>February 12, 19 62</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/10/93</b>
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Clinical Work.</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank L. Mortimer</b>		14. MOTHER'S MAIDEN NAME <b>Catherine J. Moorehead</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>219-03-1644</b>	
17. INFORMANT <b>wife, Sara A. Mortimer</b>		Address <b>Same as above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Peritonitis</b>			
578X DUE TO (b) <b>Perforation of Cecum</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>6-8, 19 62</b> to <b>2-12, 19 62</b> , that (I) (we) last saw the deceased alive on <b>2-10, 19 62</b> , and that death occurred at <b>12:45</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>W. G. Hall</b>		22b. DATE SIGNED <b>2-12-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Wm. G. Hall</b>		22d. ADDRESS <b>615 W. Montg. Ave., Rockville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2/14/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>	23d. LOCATION (City, town or county) (State) <b>Silver Spring, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Sydon Wheeler</b>		25a. REC'D BY REGISTRAR <b>1331 - 2, Montgomery Ave, Rockville, Md.</b>	
25b. REGISTRAR'S SIGNATURE		DATE <b>FEB 13 '62</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with this State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

021100

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> c. LENGTH OF STAY IN 1b <b>6-20-59/2/3/62</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Carroll Hall Sanitarium.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>DC</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington DC 47X-3</b> d. STREET ADDRESS <b>3683 Ala. Ave. SE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lizette V. Munson</b>		4. DATE OF DEATH <b>Feb. 3 1962</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 30, 1864 97</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New York City</b>	
13. FATHER'S NAME <b>Francis Adema</b>		14. MOTHER'S MAIDEN NAME <b>Mary</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>Mr. William Peck. 3683 Ala. Ave. D.C.</b>	
17. INFORMANT <b>Mr. William Peck. 3683 Ala. Ave. D.C.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HYPERTENSIVE HEART DISEASE</b> DUE TO (b) <b>CEREBRAL HEMORRHAGE</b> DUE TO (c) <b>GENERALIZED ARTERIOSCLEROSIS</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>SENILITY</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 WEEKS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>JUNE 20, 1957</b> to <b>FEB. 3, 1962</b> that (I) (we) last saw the deceased alive on <b>FEB. 3, 1962</b> , and that death occurred at <b>6:07 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Henry Lowden</b>		22b. DATE SIGNED <b>2/3/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>HENRY Lowden</b>		22d. ADDRESS <b>5206 NORWAY DR. CHEVY CHASE, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb-5-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Smithland Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Simmons Bros</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 5 '62</b>	
ADDRESS <b>1661-9d Hape Rd</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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Mr. William Lee. 300 Alh. H. 26.



## CERTIFICATE OF DEATH

Reg. Dist. **02101****02118**

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>7 YEARS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1909 GLENALLAN AVE.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>Agnes</b> Last <b>Murphy</b>		4. DATE OF DEATH Month <b>Feb</b> Day <b>10</b> Year <b>1962</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-7-76</b>
9. AGE (In years lost birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>10</b> Hours <b>10</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PENNA.</b>	
11. BIRTHPLACE (State or foreign country) <b>PENNA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>PHILIP GRAHAM</b>		14. MOTHER'S MAIDEN NAME <b>MARY JANE McDONALD</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>PAUL W. MURPHY</b>	
17. INFORMANT <b>Same as #1</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerotic heart disease</b> DUE TO (c) <b>10 yrs</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 12, 1962</b> to <b>Feb 10, 1962</b> that I last saw the deceased alive on <b>Feb 10, 1962</b> , and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>H. F. Kreuzburg</b>		M.D.	
PHYSICIAN'S NAME (Type) <b>H. F. Kreuzburg</b>		<b>7852 16 St NW Wash DC</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2-13-62</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Collins</b>		ADDRESS <b>WASH. D.C.</b>	
DATE <b>Feb 13 '62</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Thoms</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to a burial, cremation, or removal, and in any event within 72 hours after death.

102101

CERTIFICATE OF DEATH

02113

MONTGOMERY

MONTGOMERY

MONTGOMERY

SILVER SPRING

7 YEARS

SILVER SPRING

1800 STEINBLAN AV.

1800 STEINBLAN AV.

85

8-7-78

X

PERMANENT WHITE

U.S.A.

PENNA.

MONTGOMERY

MALE JAMES McDONALD

MALE JAMES McDONALD

Given as I

PAUL W. MURPHY

no

*Handwritten notes:*  
and in view of fact of  
and in view of fact of

BRANCH 1. COLLEGE ROAD, MT. W. 11-11-82  
MONTGOMERY COUNTY, M.  
MONTGOMERY COUNTY, M.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

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02119  
02102  
MONTGOMERY  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
Item 12 Film G308 3/2/62 ink

1. PLACE OF DEATH a. COUNTY MONTGOMERY				b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BETHESDA				c. LENGTH OF STAY in 1b 30 days				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Md. f. COUNTY Montgomery				g. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington, DC, (Zone 18)				h. STREET ADDRESS 2316-14th St. N.E. 47X-3				i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) FRANK NICASTRI				First Middle Last				4. DATE OF DEATH 2-15-1962				Day Month Year															
5. SEX M				6. COLOR OR RACE W				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 9/16, 1886				9. AGE (In years last birthday) 75 yrs.				IF UNDER 1 YEAR Months Days				IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer				10b. KIND OF BUSINESS OR INDUSTRY Plastering				11. BIRTHPLACE (County & State, or foreign country) Gioia Del Colle, Italy				12. CITIZEN OF WHAT COUNTRY? U.S.A.															
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give number or date of service)				17. INFORMANT Dominic J. Nicastri				Address above							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 420-1 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) DUE TO (c) Congestive heart failure Probable recurrent myocardial infarction Arteriosclerotic cardiovascular disease																INTERVAL BETWEEN ONSET AND DEATH 18 hrs 18 hrs many hrs											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																							
20c. TIME OF INJURY Hour a.m. p.m. 19				20d. INJURY OCCURRED White el work <input type="checkbox"/> Not white at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) Bethesda				20g. (County) Montgomery				20h. (State) Md.							
21. I certify that (I) (this hospital) attended the deceased from 2/15/62 to 2/15/62, and that (I) (we) last saw the deceased alive on 2/15/62 and that death occurred at 6:53 PM from the causes and on the date stated above.																											
22a. SIGNATURE John P. Martin MD				22b. DATE SIGNED 2/15/62				22c. PHYSICIAN'S NAME (Type) JOHN P. MARTIN, MD				22d. ADDRESS MEDICAL CENTER, SPOOK SPRING															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 2/19/62				23c. NAME OF CEMETERY OR CREMATORY Arlington National				23d. LOCATION (City, town or county) Arlington, Va.				23e. REC'D BY REGISTRAR DATE FEB 20 '62				23f. REGISTRAR'S SIGNATURE Arthur S. Harris							
24. FUNERAL DIRECTOR'S SIGNATURE Malley's Funeral Home Inc.				24a. ADDRESS Mt. Rainier 2nd				24b. DATE FEB 20 '62				24c. REGISTRAR'S SIGNATURE Arthur S. Harris															



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02120						02103					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			a. STATE			b. COUNTY		
Montgomery			Rockville			Maryland			Montgomery		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS		
310 Edmonston Drive						10 Rockville			310 Edmonston Drive		
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last						Month Day Year					
BERTHA J N'FONG						Feb. 25 19 62					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		May 20, 1889		72 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
Housewife				-----				North Carolina			
13. FATHER'S NAME						12. CITIZEN OF WHAT COUNTRY?					
James M. Jarvis						USA					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)						16. SOCIAL SECURITY NO.					
No						None					
17. INFORMANT						Address					
Francis Straford-daughter-same 2d											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION											
420.1 DUE TO (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
INTERVAL BETWEEN ONSET AND DEATH Moments											
years											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.											
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 19 53 to Feb 25, 19 62 that (I) (we) last saw the deceased alive on JAN 27th 19 62, and that death occurred at 9 PM, from the causes and on the date stated above.											
22a. SIGNATURE											
22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type)											
22d. ADDRESS											
22e. REC'D BY REGISTRAR											
22f. REGISTRAR'S SIGNATURE											
23a. BURIAL, CREMATION, REMOVAL (Specify)											
23b. DATE THEREOF											
23c. NAME OF CEMETERY OR CREMATORY											
23d. LOCATION (City, town or county) (State)											
24. FUNERAL DIRECTOR'S SIGNATURE											
25a. DATE											
25b. REGISTRAR'S SIGNATURE											

Burial-Transit 2/26/62

Salsbury Cemetery

Salsbury, North Carolina

Robert A. Pumphrey, Bethesda, Maryland

DATE MAR 1 '62

Wm. J. Thomas

02150

02150

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 7/61

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02121					02104				
1. PLACE OF DEATH a. COUNTY MONTGOMERY					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D.C. b. COUNTY				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) KENSINGTON, MD.			c. LENGTH OF STAY in lb 9 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C.			d. STREET ADDRESS 3620 - 16th STREET, N.W.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 10231 Carroll Place CARROLL HALL SANITARIUM					a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Middle		Last		4. DATE OF DEATH		Day Year	
CHARLOTTE		B.		NORTON		2		24 1962	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 11, 1866		9. AGE (In years last birthday) 95	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) OSWEGO, N.Y.		12. CITIZEN OF WHAT COUNTRY? USA		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
13. FATHER'S NAME BENJAMIN GREEN				14. MOTHER'S MAIDEN NAME FLORENCE COMSTOCK					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Address Same # 1 Records at Carroll Hall Sanitarium					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) bronchopneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) pulmonary edema (c), stating the underlying cause last. arteriosclerotic cardio-vascular disease DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) fracture intertrochanteric left femur on 1/15/62								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Feb 6, 1962 to Feb 24, 1962 that (I) (we) last saw the deceased alive on Feb 23, 1962, and that death occurred at 2:40 A.M. from the causes and on the date stated above.								22b. DATE SIGNED 2/24/62	
22a. SIGNATURE Alfred S. Norton				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS 4711 HIGHLAND AVE. BETHESDA, MD.			
22c. PHYSICIAN'S NAME (Type) ALFRED S. NORTON, M.D.									
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 2/27/62		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Prince Georges County, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co., 2901 14th St., N.W. Washington 9, D.C.				25a. REC'D BY REGISTRAR DATE FEB 26 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

02101

02101



D.C.

MONTGOMERY

WASHINGTON, D.C.

9/1/52

WASHINGTON, D.C.

3000 - 10th STREET, N.W.

1001 Carroll Drive  
N.W. Washington, D.C.

200

1000

1000

1000

JAN. 11, 1952

1000

USA

OSMA, N.Y.

At Home

DOMSTOCK

1000

1000

Records at Carroll Hall, N.W.

no

no

chronophenone

primary

systemic cardiac-vascular disease

Transverse intervertebral disc lesion on 11/15/52

62

62

62

1711 HIGHWAY AVE., NEWARK, N.J.

ALFRED E. HORTON, M.D.

2/21/52

1000

1000

The S. S. Atkins Co., 2001 N. 2nd St., N.W.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02122

## CERTIFICATE OF DEATH

02105

<b>1. PLACE OF DEATH</b> a. COUNTY <i>Montgomery</i> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> c. LENGTH OF STAY IN it <i>10 days</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Washington Sanitarium + Hospital</i>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <i>D.C.</i> b. COUNTY <i>✓</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Washington</i> <i>47X-3</i> d. STREET ADDRESS <i>5123 N. Capitol ST.</i>			
<b>3. NAME OF DECEASED</b> (Type or print) First <i>James</i> Middle <i>Brown</i> Last <i>Payne</i>				<b>4. DATE OF DEATH</b> Month <i>2</i> - Day <i>14</i> - Year <i>1962</i>			
<b>5. SEX</b> <i>Male</i>		<b>6. COLOR OR RACE</b> <i>white</i>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <i>7-7-80</i>	
<b>9. AGE</b> (In years last birthday) <i>81</i> yrs.		<b>IF UNDER 1 YEAR</b> Months <i>8</i> Days <i>14</i>		<b>IF UNDER 24 HRS.</b> Hours <i>14</i> Min. <i>3</i>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Retired - Route agent</i>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <i>Virginia</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U.S.A.</i>		<b>13. FATHER'S NAME</b> <i>Wallace Payne</i>		<b>14. MOTHER'S MAIDEN NAME</b> <i>Lucy Ramey</i>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <i>none</i>		<b>16. SOCIAL SECURITY NO.</b> <i>52582647</i>		<b>17. INFORMANT</b> <i>Sister - in-law.</i> Address		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchiopneumonia</i> DUE TO (b) <i>Chronic pulmonary fibrosis</i> (a), stating the underlying cause last. DUE TO (c)	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <i>Generalized arteriosclerosis severe chronic brain syndrome</i>					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <i>19</i> p.m.		<b>20d. INJURY OCCURRED</b> White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <i>2-4</i> , 19 <i>62</i> , to <i>2-14</i> , 19 <i>62</i> , that (I) (we) last saw the deceased alive on <i>2-14</i> , 19 <i>62</i> , and that death occurred at <i>2:55 A.M.</i> , from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <i>Samuel M. Baggett</i> M.D.				<b>22b. DATE SIGNED</b> <i>2/14/62</i>			
<b>22c. PHYSICIAN'S NAME</b> (Type)				<b>22d. ADDRESS</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> * (Specify) <i>Burial</i>		<b>23b. DATE THEREOF</b> <i>Feb 17 1962</i>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <i>Orleans</i>		<b>23d. LOCATION</b> (City, town or county) (State) <i>Orleans Va.</i>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Pearson Funeral Home - Ft. Elye, Falls Church, Va.</i>				<b>25a. REC'D BY REGISTRAR</b> <i>DATE FEB 16 '62</i>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Kenna</i>	

08103

UNITED STATES OF AMERICA

08103

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277707

Chicago, February 1941

Dear Mr. [Name]

Yours very truly,

Very truly yours,  
[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02123

## CERTIFICATE OF DEATH

Item 23b, Film G307 2/26/62 iwk

02106

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit</b>	
c. LENGTH OF STAY IN lb <b>2 days</b>		d. STREET ADDRESS <b>103 D Preston Drive</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. Naval Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Chris Von PEACOCK</b>		4. DATE OF DEATH <b>February 17 1962</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cauc</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>16 February 1962</b>	
9. AGE (In years last birthday) yrs. <b>2</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Montgomery, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Cecil Ray Peacock</b>		14. MOTHER'S MAIDEN NAME <b>Cytha Corinna Mitchell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>FATHER: Cecil R. Peacock, Same as #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Prematurity</b> DUE TO <b>77 6X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour e.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Feb. 16, 1962</b> , to <b>Feb. 17, 1962</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Feb. 17, 1962</b> and that death occurred at <b>3:02 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>F.A. Schulaner</b> M.D.		22b. DATE SIGNED <b>17 February 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>F.A. SCHULANER, LT MC USN</b>		22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 21, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler</b> ADDRESS <b>Tyson Wheeler, Rockville Pike, Rockville, Md.</b>		25a. REC'D BY REGISTRAR <b>Feb 21 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Flann</b>			

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U.S. Naval Hospital

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*[Handwritten signatures and text at the bottom of the page, including names like "W. J. ...", "J. ...", and "M. ..."]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02125

02108

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY in lb <u>36 days</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK 12</u> d. STREET ADDRESS <u>21 Columbia Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Gertrude Eliza Petersen</u>		4. DATE OF DEATH <u>Feb. 25, 1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-9-78</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>	9. AGE (In years last birthday) <u>83</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ralph L. Messery</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Hodges</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Washington San Hosp</u>	
17. INFORMANT <u>Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>586X</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Pulmonary failure</u> (c) <u>Emphysema</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH 1/10/62 - 7/25/62</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 10, 1962</u> to <u>Feb 25, 1962</u> , that (I) (we) last saw the deceased alive on <u>2-25-1962</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Wayne Chickfield M.D.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>WAYNE CHICKFIELD M.D.</u>		22d. ADDRESS <u>6826 Regis Road Hyattsville Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 2, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince Geo. County, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Waters</u>		25a. REC'D BY REGISTRAR <u>MAR 2 '62</u>	
ADDRESS <u>254 Carroll St, N.E. Wash, D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

03152

03150

STATE OF TEXAS

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James M. McArthur, Secretary  
James M. McArthur, Secretary  
James M. McArthur, Secretary

TO BE FILED WITH THE STATE DEPT. OF HEALTH PRIOR TO BURIAL, CREMATION, OR REMOVAL, IN ANY EVENT, WITHIN 72 HOURS AFTER DEATH. THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE EXECUTED WITHIN 24 HOURS AFTER DEATH. THE ATTENDING PHYSICIAN, WHOSE SIGNATURE IS REQUIRED, MUST BE A PHYSICIAN WHOSE NAME IS ON THE LIST OF ATTENDING PHYSICIANS MAINTAINED BY THE STATE DEPT. OF HEALTH. THE SIGNATURE OF THE ATTENDING PHYSICIAN MUST BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN. THE SIGNATURE OF THE ATTENDING PHYSICIAN MUST BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN. THE SIGNATURE OF THE ATTENDING PHYSICIAN MUST BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
02126					02109									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)									
e. COUNTY <b>Montgomery</b>					e. STATE <b>Washington</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bellevue</b>									
c. LENGTH OF STAY in 1b <b>242 days</b>					d. STREET ADDRESS <b>812-163rd Street, S.E.</b>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED					4. DATE OF DEATH									
(Type or print) <b>Margaret Lenore Phipps</b>					Last Month Day Year <b>February 11 19 62</b>									
5. SEX		6. COLOR OR RACE		7. MARRIED		8. DATE OF BIRTH		9. AGE (In years last birthday)						
<b>Female</b>		<b>White</b>		<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		<b>November 12, 1927</b>		<b>34 yrs.</b>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>						
13. FATHER'S NAME <b>Theodore W. Kenworthy</b>					14. MOTHER'S MAIDEN NAME <b>Mary M. Foster</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>535-24-2678</b>					17. INFORMANT <b>The Medical Record</b>				
					<b>The Clinical Center, Bethesda 14, Maryland</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracranial pressure due to brain metastases</b>										<b>3 weeks</b>				
DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Metastatic Choriocarcinoma</b>										<b>18 months</b>				
DUE TO (c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 14, 1961</b> to <b>February 11, 1962</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>February 11, 1962</b> , and that death occurred at <b>4:50 PM</b> from the causes and on the date stated above.														
22a. SIGNATURE <b>M. A. Kirschner</b>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <b>2/12/62</b>					22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) <b>Marvin A. Kirschner, M.D.</b>					22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>SHIP - R.R.</b>			23b. DATE THEREOF <b>2/16/62</b>		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State) <b>WASHINGTON</b>						
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. CHAMBERS Co. 1400 CHAPIN ST. N.W. WASH DC</b>					ADDRESS		25a. REC'D BY REGISTRAR <b>FEB 19 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02127

02110

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>9503 Edgeley Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Arthur F. Prior</u>		<b>4. DATE OF DEATH</b> Month <u>Feb.</u> Day <u>12</u> Year <u>1962</u>					
<b>5. SEX</b> <u>male</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>MAR 25, 1913</u>		<b>9. AGE</b> (In years last birthday) <u>48</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Exhibit maker</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U.S. Navy Exhibit Center</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Balto. Md.</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A</u>							
<b>13. FATHER'S NAME</b> <u>Joseph B. Prior</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>LILLIE E COWAN</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>215-03-9017</u>		<b>17. INFORMANT</b> <u>(Wife) EMMA LYN Prior</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>HYPERTENSION</u> (c), stating the underlying cause last. DUE TO				INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u> <u>5 or more YEARS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>CORONARY THROMBOSIS 1960</u>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u> <b>20f. (City or town)</b> <u>  </u> (County) <u>  </u> (State) <u>  </u>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>OCTOBER, 1961</u> <b>to</b> <u>FEB</u> , 1962 <b>that (I) (we) last saw the deceased alive on</b> <u>FEB 11</u> , 1962, <b>and that death occurred at</b> <u>4 A.M.</u> , <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Michael Madole</u>		<b>22b. DATE SIGNED</b> <u>Feb 12 1962</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>  </u>			
<b>22d. ADDRESS</b> <u>11406 VIERS MILL RD WHEATON MD</u>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>2/15/62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Loudon Park Cemetery</u>			
<b>23d. LOCATION</b> (City, town or county) <u>Baltimore, Maryland</u>		(State) <u>  </u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Howard H. Hubbard, 4107 Wilkens Avenue #29</u>		<b>25a. REC'D BY REGISTRAR</b> <u>  </u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>  </u>			
<b>DATE</b> <u>FEB 14 '62</u>							

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London E.C. 1, England

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02111

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN b <b>3 days</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>34 Wheaton</b>		d. STREET ADDRESS <b>12511 Atherton Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>John J. QUINLAN</b>		First		Middle		Last		4. DATE OF DEATH <b>FEB. 11 19 62</b>		Month		Day		Year			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/14.92</b>		9. AGE (In years last birthday) <b>69 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Worcester, Mass.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John J. Quinlan</b>		14. MOTHER'S MAIDEN NAME <b>Katherine O'Connor</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>yes-COULD NOT SECURE NO.</b>		17. INFORMANT <b>Mrs. Barbara Painter</b>		Address <b>Same as above</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO Congestive Heart Failure 3 years Arteriosclerotic Heart Disease 1 year Uremia due to nephrosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c). 22b. DATE SIGNED <b>2/11/62</b>		INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Braintree, Massachusetts</b>		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 11 19 62</b> to <b>Feb 11 19 62</b> that (I) (we) last saw the deceased alive on <b>Feb 11 19 62</b> and that death occurred at <b>6:30</b> M, from the causes and on the date stated above.																	
22a. SIGNATURE <b>John J. Curry M.D.</b>		22b. DATE SIGNED <b>2/11/62</b>		22c. PHYSICIAN'S NAME (Type) <b>John J. Curry</b>		22d. ADDRESS <b>10620 Georgia Ave Silver Spring</b>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. PHYS. <input type="checkbox"/>		22g. ADDRESS		22h. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-15-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Blue Hill Cemetery</b>		23d. LOCATION (City, town or county) <b>Braintree, Massachusetts</b>		23e. LOCATION (City, town or county) <b>Braintree, Massachusetts</b>		23f. LOCATION (City, town or county) <b>Braintree, Massachusetts</b>		23g. LOCATION (City, town or county) <b>Braintree, Massachusetts</b>		23h. LOCATION (City, town or county) <b>Braintree, Massachusetts</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm E. Penpley Inc.</b>		24a. ADDRESS <b>8434 Georgia Ave, SS, Md</b>		24b. REC'D BY REGISTRAR <b>FEB 14 '62</b>		24c. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>		24d. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>		24e. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>		24f. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>		24g. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

021113

021122



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME  
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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02129 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										02112	
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Montgomery</i>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. LENGTH OF STAY IN 1b <i>5 years</i>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>18 Takoma Park</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>106 Hodges Lane</i>				d. STREET ADDRESS <i>106 Hodges Lane</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Margaret</i> Middle <i>Hodges</i> Last <i>Ray</i>				4. DATE OF DEATH Month <i>Feb</i> Day <i>26</i> Year <i>1962</i>							
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>June 26, 1886</i>		9. AGE (In years last birthday) <i>75</i> yrs.		IF UNDER 1 YEAR Months <i></i> Days <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		11. BIRTHPLACE (State or foreign country) <i>Laurel Grove, Maryland</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>			
13. FATHER'S NAME <i>John W. Hodges</i>				14. MOTHER'S MAIDEN NAME <i>Sally Fawcett</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>John W. Roberts</i>		Address <i>12,506 Two Farm Dr. S.S. Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1st - 2nd + 3rd degree burns</i> <i>916.0</i> DUE TO <i>involving about 80 % of body</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i></i> DUE TO (c) <i>all clothing completely burned from body</i>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Unknown - Probably from cigarettes</i>							
20c. TIME OF INJURY Month, Day, Year Hour <i>7</i> p.m. <i>2-24-62</i>				2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, school, office bldg., etc.) <i>Home</i>		20f. (City or town) <i>Takoma Park</i>		(County) <i>Montgomery</i> (State) <i>md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <i>Frank J. Brosch</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <i>2-26-62</i>			
EXAMINER'S NAME (Type) <i>FRANK J. Brosch</i>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county) <i></i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2-28-62</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Glenwood Cemetery</i>				22d. LOCATION (City, town, or county) (State) <i>Washington, D.C.</i>			
23. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>				ADDRESS <i>434 Georgia Ave. Silver Spring, Md.</i>				24a. REC'D BY REGISTRAR <i>MAR 1 '62</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a "pending" certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02130 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02113

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY in 1b <u>D.O.A.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>35 Silver Spring</u>		d. STREET ADDRESS <u>14502 Furman Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash SAN &amp; Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>August</u> Last <u>Reader</u>				4. DATE OF DEATH Month <u>2</u> Day <u>1</u> Year <u>1962</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-5-05</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electr. Eng.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Vitro LAB</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. Reader</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Dahler</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>040-03-6398</u>		17. INFORMANT <u>William A. Reader, Jr.</u>		Address <u>2 D.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>  </u> DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> e.m. <u>  </u> p.m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>2-2-62</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <u>  </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-6-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cemetery</u>		22d. LOCATION (City, town, or county) <u>Meriden New Haven Co.</u>	
23. FUNERAL DIRECTOR <u>Raymond A. Warner</u>				24a. REC'D BY REGISTRAR <u>FEB 6 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Anthony S. Kraus</u>	

05113

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THE UNIVERSITY OF CHICAGO  
LIBRARY  
540 EAST 58TH STREET  
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AREA  
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FOR STATE  
HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

## Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02131

02114

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>52 Mins</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		d. STREET ADDRESS <b>5714 Crawford Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Norman</b>		Middle <b>Milton</b>		Last <b>Reed</b>		4. DATE OF DEATH Month <b>February</b>		Day <b>6</b>		Year <b>19 62</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>4/8/18</b>		9. AGE (In years last birthday) <b>43</b> yrs.		IF UNDER 1 YEAR Months <b>43</b>		Days <b>43</b>		IF UNDER 24 HRS. Hours <b>43</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Disabled Vet.</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Wash. D.C</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>			
13. FATHER'S NAME <b>Milton Reed</b>						14. MOTHER'S MAIDEN NAME <b>Hazel Grady</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>World War III</b>				17. INFORMANT <b>Mother Hazel Reed Same as above</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intra cerebral hemorrhages (multiple)</b> 700.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fracture of skull</b> DUE TO (c) <b>Fall down stairs</b>												INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>History of epileptic seizures in the past</b>															
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fall down stairs at home</b>											
20c. TIME OF INJURY Month, Day, Year <b>6:30 a.m. 2-6 1962</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>				20f. (City or town) (County) (State) <b>Rockville monty md</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <b>Frank J. Brochart</b>				M.D. <b>Frank J. Brochart</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Frank J. Brochart</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>2-6-62</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>2-9-62</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>				22d. LOCATION (City, town, or country) (State) <b>Arlington Va.</b>			
23. FUNERAL DIRECTOR <b>Ernest C. Gartner.</b>				ADDRESS <b>Gaithersburg. Md.</b>				24a. REC'D BY REGISTRAR <b>FEB 8 '62</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

OSI 14

OSI 14

THE TAIL  
STANDARD

(M)



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02132

## CERTIFICATE OF DEATH

Reg. Dist. No. 02115

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>D.C.</b> b. COUNTY <b>WASHINGTON</b> 47X-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>		d. STREET ADDRESS <b>250 FARRAGUT ST. N.W.</b>	
3. NAME OF DECEASED (Type or print) First <b>PATRICK</b> Middle <b>J.</b> Last <b>REILLY</b>		4. DATE OF DEATH Month <b>2</b> - Day <b>3</b> - Year <b>1962</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-22-08</b>
9. AGE (In years lost birthday) <b>53</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ATTORNEY</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't.</b>	
11. BIRTHPLACE (State or foreign country) <b>N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>PATRICK J. REILLY</b>		14. MOTHER'S MAIDEN NAME <b>CORDELIA BUCKLEY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>YES</b>		16. SOCIAL SECURITY NO. <b>WIFE</b>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage Complicated Varix</b> <b>581.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Thrombosis</b> DUE TO (c) <b>Coronary Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 1</b> , 1962, to <b>Feb 3</b> , 1962, that I last saw the deceased alive on <b>Feb 3</b> , 1962, and that death occurred at <b>12:01 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3701 Leland St. N.W. Wash. D.C.</b> DATE SIGNED <b>2-3-62</b>			
ACTUAL SIGNATURE <b>J. R. Raedy</b>		PHYSICIAN'S NAME (Type) <b>J. R. Raedy M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		22b. DATE THEREOF <b>2-4-62</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>CLAYVILLE, N. Y.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Collins</b>		24a. REC'D BY REGISTRAR <b>24b. REGISTRAR'S SIGNATURE</b>	
ADDRESS <b>3821-14th St. N.W. Wash. D.C.</b>		DATE <b>FEB 5 '62</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REMOVED - 3-2-68 St Mary's Cemetery



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02133

## CERTIFICATE OF DEATH

02116

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN b <b>29 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>26 Silver Spring,</b> d. STREET ADDRESS <b>8508 - 16th Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Faye Beatrice Reiser</b>		4. DATE OF DEATH <b>February 23, 1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1 November 1899</b>
9. AGE (In years last birthday) <b>62 yrs.</b>		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>1</b> Hours <b>1</b> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bookkeeper</b>		12. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>	
13. FATHER'S NAME <b>Abraham Snyderman</b>		14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-34-9197</b>	
17. INFORMANT <b>The Medical Record,</b>		18. CITIZEN OF WHAT COUNTRY? <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Irreversible shock</b> DUE TO (b) <b>Acute tubular necrosis</b> DUE TO (c) <b>Melanoma of Vulva</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. <b>176.7</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>9 days</b> <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>January 25, 1962</b> , to <b>February 23, 1962</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>February 23, 1962</b> , and that death occurred at <b>7:30 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Marvin Pomerantz</b> M.D.		22b. DATE <b>February 23, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Marvin Pomerantz,</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2/25/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>NAT'L MEM. PARK</b>		23d. LOCATION (City, town or county) (State) <b>FALLS CHURCH, VA.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Goldberg Funeral Home</b>		25. REC'D BY REGISTRAR <b>FEB 26 '62</b>	
25a. ADDRESS <b>4217-9th St. N.W. Wash. D.C.</b>		25b. REGISTRAR'S SIGNATURE <b>Clara S. Hanna</b>	

08113

08113



The Office of the Secretary of the Interior

Department of the Interior

Washington, D. C.

June 1, 1911

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 28th inst.

relative to the

subject of the

same.

Very respectfully,

Very truly yours,

William B. Egan

Special Agent in Charge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

<div> <div> <div>1</div> <div>02134</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> </div> <div> <div>02117</div> </div> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>56 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) STATE <b>New York</b> b. COUNTY <b>North Syracuse</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>105 Michael Avenue</b> d. STREET ADDRESS <b>69x-3</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> First Middle Last <b>Nicholas (No middle name) Renne</b>						<b>4. DATE OF DEATH</b> Month Day Year <b>February 21 1962</b>					
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>November 5, 1914</b>		<b>9. AGE</b> (In years last birthday) <b>47 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months Days Hours Min. <b>19 62</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Machine operator</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>(Not known)</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Italy</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Tom Renne</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Esther Gallo</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> <b>1943-1945</b>				<b>16. SOCIAL SECURITY NO.</b> <b>134-10-8680</b>		<b>17. INFORMANT</b> <b>The Medical Record</b> <b>The Clinical Center, Bethesda, 14, Maryland</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Aortic Stenosis and insufficiency</b> DUE TO (c) <b>Total replacement of aortic valve 3 weeks prior to death; pulmonary hypertension of unknown etiology; pulmonary emboli</b>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 hr 20 Min.</b> <b>7 years</b>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <b>19</b> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State) <b>21. I certify that I (this hospital) attended the deceased from December 27, 1961 to February 21, 1962, that I (we) last saw the deceased alive on February 21, 1962, and that death occurred at 3:50 PM from the causes and on the date stated above.</b> <b>22a. SIGNATURE</b> <b>Richard P. Anderson</b> M.D. <b>22c. PHYSICIAN'S NAME (Type)</b> <b>Richard P. Anderson, M.D.</b> <b>22b. DATE SIGNED</b> <b>2/22/62</b> <b>22d. ADDRESS</b> <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>											
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>2/26/62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Assumption</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Syracuse N.Y.</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W.W. Chambers Co.</b>				<b>25a. REC'D BY REGISTRAR</b> <b>Washington</b>				<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>			

02134



Montgomery

Postman

20 days

North of house

The Clinical Center, Bethesda, Md.

105 Marshall Avenue

Nichols

(No initials name) name

Two-way

21 22

Male

White

(Not known)

Italy

U.S.A.

Tom

Yes

1943-1945

1943-1945

The Clinical Center, Bethesda, Md.

The Medical Record

Patent office

Cardiac arrest

Acute stenosis and insufficiency

7 years

Total replacement of aortic valve 3 weeks prior to death; primary

hypertension of unknown etiology; pulmonary emboli

x

January 21 48

December 21 47

January 21 48

2/25/48

The Clinical Center, Bethesda, Md.

Director of Health, Bethesda, Md.

Richard A. Anderson, M.D.

*Handwritten notes and signatures at the bottom of the page.*

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02135  
CERTIFICATE OF DEATH  
02118

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN 1b <b>90</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Oakhaven Convalescent Home</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47X-3</b> d. STREET ADDRESS <b>6129 Broad Branch Rd. N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Flora Belle Rives</b>		4. DATE OF DEATH Month Day Year <b>February 7 19 62</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 15, 1876</b>
9. AGE (In years last birthday) <b>85</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>85 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLA. (County & State, or foreign country) <b>Mt. Juliet, Tenn</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>W. H. Young</b>		14. MOTHER'S MAIDEN NAME <b>E. Vivietta</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Ruby Stover, 6129 Broad Branch Rd.</b>		Address <b>Wash, D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>Who knows?</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <b>Feb 10 1962</b> to <b>2/17/1962</b> that (I) (we) last saw the deceased alive on <b>2/17/1962</b> and that death occurred at <b>10:00 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Chas H. WOLOTON, MD</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Cnas H. WOLOTON</b>		22d. ADDRESS <b>7401 Blair Rd NW Wash DC</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>2/8/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Nashville, Tenn.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H.Hines Co., 2901 14th St. N.W. Wash, DC</b>		25a. REC'D BY REGISTRAR <b>FEB 9 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			



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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

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MEDICAL CERTIFICATION

2

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02136 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02119											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>37 Wheaton</u>					
c. LENGTH OF STAY IN 1b <u>1 1/2 mo</u>						d. STREET ADDRESS <u>2505-Newton st</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2505 Newton st</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Patricia Jane Roberson</u>						4. DATE OF DEATH <u>Feb 2 1962</u>					
5. SEX <u>Female</u>						6. COLOR OR RACE <u>White</u>					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <u>8-28-25</u>					
9. AGE (In years last birthday) <u>36 yrs.</u>						10. IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>typist</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>					
11. BIRTHPLACE (State or foreign country) <u>DC</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Arthur J. Hogan</u>						14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Cavanaugh</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>						16. SOCIAL SECURITY NO. <u>578-24-1221</u>					
17. INFORMANT <u>Rose Johnson</u>						Address <u>Stuen 2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thoracic hemorrhage</u> DUE TO (b) <u>Bullet wounds in heart + chest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>981X</u>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot by husband on street leaving in car for work</u>					
20c. TIME OF INJURY Month, Day, Year <u>8:00 a.m. 2-2 1962</u>						20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> et work <input checked="" type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>						20f. (City or town) <u>Wheaton</u> (County) <u>Montgomery</u> (State) <u>md</u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Brosch</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						22b. DATE THEREOF <u>2-6-62</u>					
22c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Cemetery</u>						22d. LOCATION (City, town, or country) (State) <u>Falls Church Fairfax Virginia</u>					
23. FUNERAL DIRECTOR <u>Raymond Q. Zick</u> ADDRESS <u>4454 Georgia Ave.</u>						24a. REC'D BY REGISTRAR <u>FEB 6 '62</u>					
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>											

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James E. Purdy, Inc. - Silver Spring, Md.

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FOR STATE  
HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02120

02137

Arlington

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Virginia</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i> Arlington			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>In front of 3005 Newton St.</i>				e. STREET ADDRESS <i>711 So. 20th Street</i>			
3. NAME OF DECEASED (Type or print) <i>William V. Roberson</i>				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <i>Male</i>				6. COLOR OR RACE <i>White</i>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <i>9-2-92</i>			
9. AGE (In years last birthday) <i>69</i> yrs.				10. IF UNDER 1 YEAR Months Days			
11. IF UNDER 24 HRS. Hours Min.				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Navy yard</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>retired</i>			
13. FATHER'S NAME <i>Unknown</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>				16. SOCIAL SECURITY NO. <i>WW-1</i>			
17. INFORMANT <i>Pearson Funeral Home, Falls Church, Va.</i>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage &amp; laceration</i> DUE TO (b) <i>bullet wound in rt temple</i> DUE TO (c) <i>bullet wound in rt temple</i>				INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Self-inflicted bullet wound in rt temple</i>			
20c. TIME OF INJURY Month, Day, Year <i>8:15 am 2-2-1962</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Auto</i>				20f. (City or town) <i>Wheaton</i> (County) <i>Monty</i> (State) <i>Ind</i>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Frank J. Broschart</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>FRANK J. BROSCHE</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				22b. DATE THEREOF <i>2-6-62</i>			
22c. NAME OF CEMETERY OR CREMATORY <i>Arlington National Cemetery</i>				22d. LOCATION (City, town, or country) <i>Arlington</i> (State) <i>Virginia</i>			
23. FUNERAL DIRECTOR <i>Raymond A. Ziska</i> ADDRESS <i>8434 Georgia Ave</i>				24a. REC'D BY REGISTRAR <i>Warner E. Pumphrey, Inc. Silver Spring, Md.</i>			
24b. REGISTRAR'S SIGNATURE <i>Anthony S. Thomas</i>				DATE <i>FEB 6 '62</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02138

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02121

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Bethesda</u>			
c. LENGTH OF STAY IN 1b <u>1 yr</u>				d. STREET ADDRESS <u>5300 Westland Rd. apt 348</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5300 Westland Rd. apt 348</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ben Palmer Roberson</u>				4. DATE OF DEATH <u>Feb 2 1962</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-21-1905</u>	
9. AGE (in years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>air cond. Refrig</u>			
11. BIRTHPLACE (State or foreign country) <u>N.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Jan A Roberson</u>				14. MOTHER'S MAIDEN NAME <u>Katie S. Drew</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>130-09-6504</u>			
17. INFORMANT <u>Stuart Roberson</u>				Address <u>4735 Chain Bridge Rd McLean VA</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Myocardial Insufficiency</u> Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Arteriosclerosis</u> (c) <u>  </u> DUE TO <u>  </u> cause last. <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>  </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Brosch</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>2-3-62</u>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/7/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>		22d. LOCATION (City, town, or country) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>  </u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			
DATE <u>FEB 9 '62</u>							

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Robert A. Thompson, Attorney  
Washington, D.C.  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02139

## CERTIFICATE OF DEATH

Item 9 Film G307 2/19/62 iwk

02122

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Pleasant view nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> d. STREET ADDRESS <b>Horners Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ANDERSON</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>3</b> Year <b>19 62</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 4, 1882</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>79 89</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13. FATHER'S NAME <b>Alfred Ross</b>		14. MOTHER'S MAIDEN NAME <b>Adelaine Warren</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-sclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Squamous cell Carcinoma of jaw.</b> DUE TO (c) <b>Metastasis To Neck.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>August 1961</b> to <b>Feb 3</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>Feb 1st 1962</b> , and that death occurred at <b>12 M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Luciano I. Leal</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Luciano I. Leal</b>		22d. ADDRESS <b>Gaithersburg</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2/7/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Park Cem.</b>	23d. LOCATION (City, town or county) (State) <b>Rockville, Md</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 13 '62</b>	
ADDRESS <b>Rockville, Md</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

SS:SD

263

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02140

## CERTIFICATE OF DEATH

02123

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <u>D.C.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b <u>WASH. D.C. 47X.3</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASH. D.C. 47X.3</u>		d. STREET ADDRESS <u>718 OGLETHORPE ST. N.W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON SANITARIUM &amp; HOSP</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Lenae - Rubinton</u>				<b>4. DATE OF DEATH</b> Last Middle First <u>2 11 1962</u>			
<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>W.</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>MARCH 8 - 1903</u>	
<b>9. AGE</b> (In years last birthday) <u>78</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>RUSSIA</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>UNKNOWN</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>UNKNOWN</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>		<b>17. INFORMANT</b> <u>SAMUEL RUBINTON</u>		Address <u>835 FAIR OAK AVE HYATTSMD</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Cerebral Arteriosclerosis</u> (c)						INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u> <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>3/2</u> , 19 <u>59</u> , to <u>2/11</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>2/11</u> , 19 <u>62</u> , and that death occurred at <u>7:40</u> P.M., from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Irving W. Winik</u>				<b>22b. DATE SIGNED</b> <u>2/11/62</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Irving W. Winik</u>				<b>22d. ADDRESS</b> <u>3908 McKinlay St. N.W.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>2/13/62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>DC LODGE Cem</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Wash DC</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Seaberg Funeral Home</u>				<b>24b. ADDRESS</b> <u>4217-9th Ave</u>		<b>25a. REC'D BY REGISTRAR</b> <u>DATE 13 '62</u>	
				<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kenna</u>			

05150

STATE OF TEXAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02141  
CERTIFICATE OF DEATH  
02124

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) e. STATE <b>Virginia</b> <b>Fairfax</b> b. COUNTY <b>Fairfax</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Herndon</b> <b>15X-1</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Poolesville</b>		c. LENGTH OF STAY IN lb <b>12 yrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>Mary Francis Rutter</b>		4. DATE OF DEATH Month <b>Feb</b> Day <b>24</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 7 1878</b>
9. AGE (In years last birthday) <b>83</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House keeping--Own home</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Fairfax Co. Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Henry Rutter</b>		14. MOTHER'S MAIDEN NAME <b>Francis Lanham</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Charles Rutter, Poolesville, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Influenza, Type Undetermined</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <b>4 8 1 X</b> (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arteriosclerotic Cardiovascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>24 Jan. 1962</b> to <b>24 Feb. 1962</b> , that (I) (we) last saw the deceased alive on <b>23 Feb 1962</b> , and that death occurred at <b>9:45 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Gordon M. Smith</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Gordon M. Smith</b>		22d. ADDRESS <b>Barnesville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE THEREOF <b>2/27/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Chesnut Grove</b>		23d. LOCATION (City, town or county) (State) <b>Herndon, Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Constance C. Hilton</b>		24b. REC'D BY REGISTRAR <b>FEB 28 '62</b>	
ADDRESS <b>Barnesville, Md</b>		25b. REGISTRAR'S SIGNATURE <b>Charles L. Kline</b>	

(M)

02121

02121

Montgomery

Virginia

Leitner

Booleville

12 yrs

Herndon

Female White

June 7 1878

Feb

Butler

Princeton

Gay

House keeping--own home

F. Linker Co. Virginia

U.S.

Francis Lanning

Henry Butler

Charles Butler, Booleville, Maryland

No

Gordon M. Smith

Chester above

Herndon, Va.

Booleville, Md



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02142

## CERTIFICATE OF DEATH

02125

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> c. LENGTH OF STAY IN lb <u>1 mo. 10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kensington Gardens Sanitorium</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>—</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON, D.C.</u> d. STREET ADDRESS <u>2127 - California St. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Lula D. Ryburn</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>2 - 7 - 1962</u>					
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>NOV. 3, 1884</u>	<b>9. AGE</b> (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR: Months <u>3</u> Days <u>4</u> IF UNDER 24 HRS.: Hours <u>—</u> Min. <u>—</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>RET. CLERK - U.S. GOVT. - Public Health Ser.</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>—</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>SMITH COUNTY, VA.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>F. Grundy Davis</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Elizabeth Snadley</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMY OR FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes give war or date of service)		<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>		<b>17. INFORMANT</b> Address <u>MR. H. F. DAVIS (Bro.)</u> <u>UNIV. OF SO. CALIF., COLUMBIA, SO. CALIF.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Insanition - Unknown</u> DUE TO (b) <u>Myocardial - Infarct</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>			
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>Jan 27, 1962</u> to <u>Feb 7, 1962</u> ; that (I) (we) last saw the deceased alive on <u>Feb 5, 1962</u> , and that death occurred at <u>9:30 PM</u> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Robert T. Thibadeau M.D.</u>		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>2-7-62</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>ROBERT T. THIBADEAU</u>		<b>22d. ADDRESS</b> <u>KENSINGTON, MD 2-7-62</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>	<b>23b. DATE THEREOF</b> <u>FEB. 10/62</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>RICH VALLEY PRES. CH. CEM.</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>MARION, VIRGINIA</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Martin W. Hyson Co.</u>		<b>ADDRESS</b> <u>1300 - N. N.W., WASH. DC</u>		<b>25a. REC'D BY REGISTRAR</b> DATE <u>FEB 13 '62</u>			
				<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles S. Kraus</u>			

25150

22520

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CENTRAL MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02143

02126

1. PLACE OF DEATH a. COUNTY <i>Montgomery County</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> c. LENGTH OF STAY IN 1b <i>47</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>RESMOR Hospital</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>MONTGOMERY</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>BETHESDA</i> d. STREET ADDRESS <i>5100 BRADLEY Boulevard</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Rollo RAY SABINE</i>		4. DATE OF DEATH Month Day Year <i>FEB 26 1962</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 31, 1891</i>
9. AGE (In years last birthday) <i>71</i> yrs.		IF UNDER 1 YEAR Months Days <i>1 25</i>	IF UNDER 24 HRS. Hours Min. <i>1 25</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>draughtsman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U. S. Government</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Nebraska</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>George Washington Sabine</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Fancy</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>W.W.I</i>	
17. INFORMANT <i>Ada E. Sabine-Wife-Same Item #2</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Terminal bronchio pneumonia</i> <i>332 X</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Cerebral thrombosis</i> (c) DUE TO cause last. (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <i>amyotrophic lateral sclerosis</i> 10 yrs.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>MAR 22, 1954</i> to <i>FEB 25, 1962</i> , that (I) (we) last saw the deceased alive on <i>FEB 25, 1962</i> , and that death occurred at <i>1:45 P.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>E.E. Quayle M.D.</i>		22b. DATE SIGNED <i>2-25-62</i>	
22c. PHYSICIAN'S NAME (Type) <i>E.E. Quayle M.D.</i>		22d. ADDRESS <i>1822 Bittmore St NW, Washington D.C.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>March 1, 1962</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Hebron</i>		23d. LOCATION (City, town or county) (State) <i>Winchester Virginia</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>		25a. REC'D BY REGISTRAR <i>DATE MAR 1 '62</i>	
ADDRESS <i>Bethesda, Maryland</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

(M)

Robert A. Murphy, Bethesda, Maryland

March 1, 1968, Hebron

Born

Mr. Murphy

Mr. Murphy

File 45

Mar 28 1968

X

2-25-68

Winchester, Virginia

Residence 21 NW Washington

Psychiatric follow-up

Notes

Yes

None

Ada E. Jelinek-Wie-sans from 12

George Washington Jelinek

Elizabeth J. Jelinek

U. S. Government, Nebraska

USA

Jan. 31, 1961

28

02144

## CERTIFICATE OF DEATH

Reg. Dist. No. 02127

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>920-NORTHWEST DRIVE</b>		d. STREET ADDRESS <b>1920 NORTHWEST DRIVE</b>	
3. NAME OF DECEASED (Type or print) First <b>Emanuel</b> Middle Last <b>Sachs</b>		4. DATE OF DEATH Month <b>2</b> Day <b>25</b> Year <b>1962</b>	
5. SEX <b>m</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 5, 1892</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MERCHANT-RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>LITHUANIA</b>	
11. BIRTHPLACE (State or foreign country) <b>LITHUANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>YIDEL SACHS</b>		14. MOTHER'S MAIDEN NAME <b>LEAH -</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes NO</b>		16. SOCIAL SECURITY NO. <b>577-48-2270</b>	
17. INFORMANT <b>ROBERT SACHS-8110 TAHONA DR. S.S. MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute myocardial infarct</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <b>Coronary atherosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>18 hours</b> <b>12 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/19, 1950</b> to <b>2/25, 1962</b> that I last saw the deceased alive on <b>1/9, 1962</b> , and that death occurred at <b>3:20</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3900 McKinley St. N.W. Washington D.C.</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Irving W. Winik</b>		M.D. <b>3900 McKinley St. N.W. Washington D.C.</b>	
PHYSICIAN'S NAME (Type) <b>Irving W. Winik</b>		<b>Washington D.C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>2-27-62</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ANSHE EMUNAH CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Pongensky + Sons</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 28 '62</b>	
ADDRESS <b>3501-14864 Ave</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05123

CENTRAL AIR OF DEATH

05123

1

FLIGHT-CHART

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
02145					02128									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)									
a. COUNTY <b>Montgomery</b>					a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>17 Takoma Park</b>									
c. LENGTH OF STAY IN 1b <b>13 hrs</b>					d. STREET ADDRESS <b>14 Philadelphia Avenue</b>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED					4. DATE OF DEATH									
(Type or print)					Month Day Year									
<b>Mary Ritchie Scott</b>					<b>Feb. 17, 1962</b>									
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 9, 1877</b>		9. AGE (In years last birthday) <b>84 yrs.</b>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.						
13. FATHER'S NAME <b>David W. Peters</b>					14. MOTHER'S MAIDEN NAME <b>Annie S. Ritchie</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT <b>Marian Portillo (daughter)</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, early</b> DUE TO (b) <b>Inaction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Carcinoma of breast, right.</b>										INTERVAL BETWEEN ONSET AND DEATH				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)				
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 19 58</b> to <b>Feb 17 62</b> , that (I) (we) last saw the deceased alive on <b>2-16-62</b> , and that death occurred at <b>3:44</b> M, from the causes and on the date stated above.														
22a. SIGNATURE <b>Bernard H. Fitzgerald</b>					22b. DATE SIGNED <b>2-17-62</b>					22c. PHYSICIAN'S NAME (Type) <b>Bernard Fitzgerald, M.D.</b>				
22d. ADDRESS <b>217 Univ. Blvd E. Sd., Md.</b>					22e. REC'D BY REGISTRAR DATE <b>FEB 20 '62</b>									
23a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Entombment Feb. 20, 1962</b>					23b. DATE THEREOF					23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Mausoleum</b>				
23d. LOCATION (City, town or county) <b>Prince George Co. Maryland</b>					23e. REGISTRAR'S SIGNATURE <b>Arthur Walters</b>									
23f. ADDRESS <b>254 Carroll St. N.W. Wash. D.C.</b>					23g. REGISTRAR'S SIGNATURE <b>Arthur Walters</b>									

02158

02158

M

I

Handwritten notes and signatures at the bottom of the page, including a signature that appears to read "James H. [illegible]" and other illegible text.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02146

## CERTIFICATE OF DEATH

02129

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>✓</u>											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. LENGTH OF STAY IN 1b <u>60 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Arlington</u>		d. STREET ADDRESS <u>813 South Veitch Street</u>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Bertha</u> Middle <u>Christina</u> Last <u>Sergeant</u>				<b>4. DATE OF DEATH</b> Month <u>February</u> Day <u>27</u> Year <u>19 62</u>											
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>Caucasian</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>February 26, 1896</u>									
<b>9. AGE</b> (In years last birthday) <u>66</u> yrs. <table border="1"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.						
IF UNDER 1 YEAR		IF UNDER 24 HRS.													
Months	Days	Hours	Min.												
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Washington</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>									
<b>13. FATHER'S NAME</b> <u>John G. Carlson</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Olivie Bahlblon</u>											
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>- - - - -</u>		<b>17. INFORMANT</b> <u>HUSBAND: Russell C. Sergeant, Same as #2</u>											
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma paraxial</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)									
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Dec. 29, 1961</u> to <u>Feb. 27, 1962</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Feb. 27, 1962</u> and that death occurred at <u>1:25 AM</u> from the causes and on the date stated above.															
<b>22a. SIGNATURE</b> <u>Vernon N. Houk</u> M.D.				<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>February 27, 1962</u>									
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>VERNON N. HOUK LCDR MC USN</u>				<b>22d. ADDRESS</b> <u>U. S. Naval Hospital, Bethesda, Md.</u>											
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>3/2/62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Arlington, Virginia</u>									
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Arthur S. Harris</u> <u>Arlington Funeral Home, 3901 N. Fairfax Dr.</u>				<b>25a. REC'D BY REGISTRAR</b> <u>DATE MAR 5 '62</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Harris</u>									

08123

08146

(M)

U. S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

TO : DIRECTOR, FBI (100-371000)  
FROM : SAC, NEW YORK (100-100000) (P)  
SUBJECT: [Illegible]

[The following text is mirrored and largely illegible due to bleed-through from the reverse side of the page. It appears to be a memorandum or report detailing an investigation.]

RE: [Illegible]

DATE: [Illegible]

BY: [Illegible]

100-371000-1000

13  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02147 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02130

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> <u>D.C.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>34 Wheaton</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash Saint Hosp</u>				d. STREET ADDRESS <u>12412 Oakwood Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Tobias Siegel</u>				4. DATE OF DEATH <u>2 8 1962</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-29-11-30</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Milkman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dairy</u>		11. BIRTH PLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William Siegel</u>				14. MOTHER'S MAIDEN NAME <u>Augusta Hechstim</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>053-07-0378</u>		17. INFORMANT <u>Sue Siegel - Same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u></u> (a), stating the underlying cause last. DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSCANT</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>2-8-62</u>			
				Address (Street, city, town, or county) <u></u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/11/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MONTEFIORE CEM.</u>		22d. LOCATION (City, town, or country) (State) <u>QUEENS. N.Y.</u>	
23. FUNERAL DIRECTOR <u>Dealing Funeral Home</u>				ADDRESS <u>4217-9th</u>		24a. REC'D BY REGISTRAR <u>13 '62</u>	
				24b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>			

MEDICAL CERTIFICATION

03150

03150





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled up by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
02148 Item 9 Film G308 3/13/62 iwk 02131									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont. Co.</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>					c. LENGTH OF STAY IN 1b <u>18 days</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>					d. STREET ADDRESS <u>7615 Lynnhaven</u>				
3. NAME OF DECEASED (Type or print) <u>Lynne C. Smeby</u>					4. DATE OF DEATH <u>Feb. 28 1962</u>				
5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u>					7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>9/1/03</u>				
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. AGE (In years, last birthday) <u>58</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>radioengineer</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Communications</u>				
11. BIRTHPLACE (County & State, or foreign country) <u>Minnesota</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Helge Smeby</u>					14. MOTHER'S MAIDEN NAME <u>Minnie Peterson</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give year or dates of service)					16. SOCIAL SECURITY NO. <u>760</u>				
17. INFORMANT <u>Evelyn Smeby</u> Address <u>Same</u>					18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary infarct, rt. lower lobe</u> 465X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Thrombosis, pulmonary artery, rt. lower lobe branch</u> (c) <u>Thrombosis, pulmonary artery, rt. lower lobe branch</u> DUE TO cause test.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>FEB. 1954</u> to <u>2/28/62</u> , that (I) (we) last saw the deceased alive on <u>2/28/62</u> , and that death occurred <u>10 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Charles J. J. J.</u> M.D.					22b. DATE SIGNED <u>2/28/62</u>				
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>					23b. DATE THEREOF <u>3-3-62</u>				
23c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY</u>					23d. LOCATION (City, town or county) (State) <u>WASHINGTON D.C.</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>Peter T. Salamon</u>					25a. REC'D BY REGISTRAR <u>5 '62</u>				
25b. REGISTRAR'S SIGNATURE <u>William S. Jones</u>									

5103 Wisc. Ave - Wash. 16, D.C.

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*[Faint, illegible handwriting, likely bleed-through from the reverse side of the page.]*

*[Faint, illegible handwriting at the bottom of the page, possibly a signature or date.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1-5  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02149  
02132

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 8 days		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE D. C.		b. COUNTY Washington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital,						d. STREET ADDRESS 3744 Huntington Street						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William		Middle George		Last Smith		4. DATE OF DEATH Month February		Day 5,		Year 19 62			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1876 August 28, 1875		9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months 5		IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Naval Officer				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (Country & State, or foreign country) Ireland				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Smith						14. MOTHER'S MAIDEN NAME Mary Armstrong							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes Unknown						16. SOCIAL SECURITY NO. - - - - -						17. INFORMANT Address SON: William G. Smith Jr., Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer Prostate with metastasis 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (this hospital) attended the deceased from Jan. 28, 1962 to Feb. 5, 1962, that (we) last saw the deceased alive on Feb. 5, 1962, and that death occurred at 11:00AM from the causes and on the date stated above. 22a. SIGNATURE Joseph H. Eusterman M.D. 22b. DATE SIGNED February 5, 1962 22c. PHYSICIAN'S NAME (Type) JOSEPH H. EUSTERMAN LT MC USN 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 2-9-62		23c. NAME OF CEMETERY OR CREMATORY Arlington				23d. LOCATION (City, town or county) (State) Arlington, Va.			
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ROBERT A. PUMPHREY Funeral Home, 7557 Wisc. Ave.,						ADDRESS Beth., Md.		25a. REC'D BY REGISTRAR DATE FEB 7 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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JOSEPH H. BURKE  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02150

02133

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>42 Kensington</u>	
c. LENGTH OF STAY IN lb <u>23 days</u>		d. STREET ADDRESS <u>3924 Baltimore Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ida M. Snyder</u>		4. DATE OF DEATH <u>Feb, 11 1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/26/83</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. Gort, Wash. D.C.</u>	9. AGE (In years birthdate) <u>78</u> yrs. IF UNDER 1 YEAR Months <u>4</u> Days <u>12</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George H. II</u>		14. MOTHER'S MAIDEN NAME <u>Meredith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Niece - C. Campbell</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral Thrombosis</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>arterio sclerosis</u> (a), stating the underlying cause last. DUE TO (c) <u>cardio Vascular Renoldisease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>cholecystectomy, excision of kidney cyst 1-29-62</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-19-</u> , <u>1962</u> to <u>2-11-</u> , <u>1962</u> that (I) <u>(me)</u> last saw the deceased alive on <u>2-11-</u> , <u>1962</u> , and that death occurred at <u>7P</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>John O. Robben M.D.</u>		22b. DATE SIGNED <u>2-11-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>John O. Robben</u>		22d. ADDRESS <u>10511 Summit Ave. Kensington, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/15/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince George Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>FEB 15 '62</u>	
ADDRESS <u></u>		25b. REGISTRAR'S SIGNATURE <u></u>	

02150

02150

John H. Cobden

10311 Summit Ave. Kensington, Md.

Robert A. Tupper, Bethesda, Maryland

St. Lincoln Cemetery, Prince Georges Co. Md.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02151

## CERTIFICATE OF DEATH

02134

M

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 6 days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Pennsylvania		b. COUNTY Clearfield		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 75x3		d. STREET ADDRESS 9 Apple Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) John		First E. D.		Middle Snyder		Last February 20, 19 62		4. DATE OF DEATH Month Day Year		5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 10, 1920		9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Snyder		14. MOTHER'S MAIDEN NAME Katherine Wise		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 173 18 7987		17. INFORMANT Hospital Records		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Myocardial Infarction Acute and Chronic (c) DUE TO (e), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)																19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)																20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)													
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Feb. 14, 1962 to Feb. 20, 1962 that (ix) (we) last saw the deceased alive on Feb. 20, 1962, and that death occurred 12:55 AM from the causes and on the date stated above.																							
22a. SIGNATURE William P. Baker												M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED February 20, 1962							
22c. PHYSICIAN'S NAME (Type) WILLIAM P. BAKER LT MC USN												22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/24/62		23c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery		23d. LOCATION (City, town or county) Clearfield, Penna.		(State)															
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey																ADDRESS Bethesda, Md. 7557 Wisc. Ave.,		REC'D BY REGISTRAR DATE FEB 23 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Kenna			

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CERTIFICATE OF DEATH

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Pennington

Honorable

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(Date)

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U. S. Naval Hospital

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May 10, 1920

U. S. Naval Hospital

May 10, 1920

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
15M 9/60

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02152  
MONTGOMERY  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
02135

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital</b>		d. STREET ADDRESS <b>33 13501 Grenoble Dr. Rockville</b>	
3. NAME OF DECEASED (Type or print) <b>Frederick William Spielman</b>		4. DATE OF DEATH <b>February 10 1962</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-3-92</b>
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sewing machine Co.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Hagerstown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles E. Spielman</b>		14. MOTHER'S MAIDEN NAME <b>Emma A. Danner</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>1917-1918 186-07-8066</b>	
17. INFORMANT <b>wife - Elizabeth Spielman</b>		Address <b>same 2d</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>coronary occlusion April, 1958</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>February 5, 1962</b> to <b>February 10, 1962</b> that (I) (we) last saw the deceased alive on <b>Feb 10, 1962</b> , and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Stephen C. Cromwell</b> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>Stephen C. Cromwell, MD</b>		22b. DATE SIGNED <b>2/10/62</b>	
22d. ADDRESS <b>Rockville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/13/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		ADDRESS	
25a. REC'D BY REGISTRAR <b>FEB 14 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
02153					02136									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)									
a. COUNTY <b>Montgomery</b>					a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>39 Silver Spring</b>									
c. LENGTH OF STAY IN 1b <b>5 1/2 days</b>					d. STREET ADDRESS <b>10410 Inwood Avenue</b>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH									
First <b>Aleksandra</b> Middle <b>Stankunas</b> Last <b>Stankunas</b>					Month <b>February 2,</b> Day <b>19</b> Year <b>62</b>									
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/18/82</b>		9. AGE (In years last birthday) <b>79 yrs.</b>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Lithuania</b>		12. CITIZEN OF WHAT COUNTRY? <b>Naturalized US</b>								
13. FATHER'S NAME <b>Alex Yutz</b>					14. MOTHER'S MAIDEN NAME <b>Unknown</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>					16. SOCIAL SECURITY NO. <b>none</b>					17. INFORMANT <b>Francis C. Stann, 2518 Plyers Mill Rd., Sil. Sp., Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>				
PART I. DEATH WAS CAUSED BY: <b>332X</b> IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO (b) <b>Generalized Arterio Sclerosis</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>10670 Georgia Ave</b>		(County) <b>Ind</b>						
21. I certify that (I) (this hospital) attended the deceased from <b>Mar 2 1955</b> to <b>Feb 2 1962</b> that (I) (we) last saw the deceased alive on <b>Feb 2 1962</b> and that death occurred at <b>2:30 PM</b> from the causes and on the date stated above.										22b. DATE SIGNED <b>2-2-62</b>				
22a. SIGNATURE <b>John J. Curry M.D.</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. PHYSICIAN'S NAME (Type) <b>JOHN J. CURRY</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit -2-2-62</b>					23b. DATE THEREOF <b>-2-2-62</b>					23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary Magdelene Cem.</b>				
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>					ADDRESS <b>Bethesda, Md.</b>					25a. REC'D BY REGISTRAR DATE <b>FEB 7 '62</b>				
										25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>				

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DISCUSSION AND CONCLUSIONS



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HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02154 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02137											
Items 1, 6 & 7 Film Q308 3/5/62 ink											
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Montg</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville (rural)</i>				c. LENGTH OF STAY in lb <i>D.O.A.</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>56 Chevy Chase 15</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>at ocean of suicide</i>				d. STREET ADDRESS <i>15520 Wooten Ave</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Alfred Francis Stanton Jr</i>				4. DATE OF DEATH <i>Feb 23 1962</i>							
5. SEX <i>male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10-23-35</i>		9. AGE (In years last birthday) <i>26 yrs</i>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Auto</i>				11. BIRTHPLACE (State or foreign country) <i>New York</i>			
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				13. FATHER'S NAME <i>Alfred Francis Stanton</i>				14. MOTHER'S MAIDEN NAME <i>Helena Dykstra</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>				16. SOCIAL SECURITY NO. <i>Korean 262-46-9255</i>				17. INFORMANT <i>Helena Stanton-Item# 2</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage &amp; laceration</i> 978X DUE TO (b) <i>Bullet wound Thru skull</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <i></i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <i></i>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Self-inflicted bullet wound Thru skull</i>							
20c. TIME OF INJURY Month, Day, Year <i>2-23 1962</i>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Wooten Rd Rockville Montg Md</i>			
20f. (City or town) <i>Rockville</i>				20g. (County) <i>Montg</i>				20h. (State) <i>Md</i>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Bur-transit</i>				22b. DATE THEREOF <i>2/28/62</i>				22c. NAME OF CEMETERY OR CREMATORY <i>Pine Lawn National</i>			
22d. LOCATION (City, town, or country) <i>Long Island, New York</i>				22e. (State) <i></i>							
23. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Md.</i>				23a. ADDRESS <i></i>				24a. REC'D BY REGISTRAR <i>FEB 27 '62</i>			
24b. REGISTRAR'S SIGNATURE <i>Carlton S. Kraus</i>				24c. DATE <i></i>							

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*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "MAY 1964" and "RECEIVED" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>2 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> f. COUNTY <b>St. Mary's</b> g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park</b> h. STREET ADDRESS <b>#4 Taylor, Carver Heights</b> i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>KIMBERLEE LEVERN STOUT</b> First Middle Last <b>Kimberlee Levern Stout</b>		4. DATE OF DEATH Month Day Year <b>February 7, 1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negroid</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Month Day Year <b>Feb. 5, 1962</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		9b. KIND OF BUSINESS OR INDUSTRY -----	9. AGE (In years last birthday) yrs. --- Months --- Days --- Hours --- Min. --- <b>2</b>
10a. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		10b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. FATHER'S NAME <b>Donald William Stout</b>		12. MOTHER'S MAIDEN NAME <b>Dorothy Louise Jackson</b>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		14. SOCIAL SECURITY NO. -----	
15. INFORMANT <b>Hospital Records</b>		Address -----	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prenatality</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) ----- (a), stating the underlying cause last. (c) ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ----- INTERVAL BETWEEN ONSET AND DEATH -----			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. ----- <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State) -----
21. I certify that <b>he</b> (this hospital) attended the deceased from <b>Feb. 5, 1962</b> , to <b>Feb. 7, 1962</b> , that <b>he</b> (we) last saw the deceased alive on <b>Feb. 7, 1962</b> , and that death occurred at <b>1:45 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Bernard H. Feldman</b> M.D.		22b. DATE SIGNED <b>February 7, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>BERNARD H. FELDMAN LT MC USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2-9-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>B. F. TAYLOR</b> ADDRESS <b>909 6th ST. WASH. D.C.</b>		25a. REC'D BY REGISTRAR <b>FEB 9 '62</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>

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U. S. NATIONAL ARCHIVES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural)		c. LENGTH OF STAY IN lb 48 days		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Md. (D.C.)		b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Washington		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) DAVID HUNT STUART		4. DATE OF DEATH February 22 1962		5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3 August 1885 7677		9. AGE (In years last birthday) yrs. 76 77		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		11. BIRTHPLACE (County & State, or foreign country) Wythe County, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter Stuart		14. MOTHER'S MAIDEN NAME Elizabeth St. Clair		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. 577 48 4935		17. INFORMANT Mrs. Fay M. Stuart (wife) 4703 Dover Rd.,		Address Washington 16, D.C.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of colon 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21. I certify that (this hospital) attended the deceased from 2 February, 1962, to 22 February 1962, that (we) last saw the deceased alive on 22 February 1962, and that death occurred at 1207 P.M. from the causes and on the date stated above.		22a. SIGNATURE Clifford M. Herman M.D.		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) CLIFFORD M. HERMAN LT MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Maryland		22e. REC'D BY REGISTRAR		22f. REGISTRAR'S SIGNATURE							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/27/62		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Virginia		24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Funeral Home, 7557 Wisc. Ave		24a. ADDRESS Bethesda, Md.		24b. DATE FEB 26 '62		24c. REGISTRAR'S SIGNATURE					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with this State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>20 Silver Spring</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>1 8717 Piney Branch Rd</u> S.S. Md	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lillian</u> First Middle Last <u>C. SUSMAN</u>		4. DATE OF DEATH Month <u>2</u> Day <u>14</u> Year <u>1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 6 1913</u> 48 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>48</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Max Forest</u>		14. MOTHER'S MAIDEN NAME <u>Yetta Friedman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service)		17. INFORMANT <u>Jack Susman</u> Address <u>8717 Piney Branch Rd S.S. Md.</u>	
16. SOCIAL SECURITY NO. <u>092-07-477</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Malignant hypertension</u> DUE TO (c) <u>24 hrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/13</u> , 19 <u>62</u> to <u>2/14</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>2/14</u> , 19 <u>62</u> , and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Mildred G. Edelman</u> M.D.		22b. DATE SIGNED <u>2/14/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>MILDRED G. EIDELMAN-M.D.</u>		22d. ADDRESS <u>1602-DILSTON RD. S.S. MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-16-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MT. MORIAH CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>FAIRVIEW N.J.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>BERNARD DANZANSKY &amp; SONS - 3501-14th ST NW</u>		25a. REC'D BY REGISTRAR <u>FEB 16 '62</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. 02141

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Le Deau Napping Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Carrie</u> First <u>Sutton</u> Middle <u>Sutton</u> Last <u>Sutton</u>				4. DATE OF DEATH <u>Feb</u> Month <u>27</u> Day <u>27</u> Year <u>1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 31, 1882</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>20</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John H. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Francis Maddox</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Marie Garadi-daughter-same 2d</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malignant Melanoma of the left eye with metastasis</u> DUE TO <u>192x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u>19</u> Month <u></u> Day <u></u> Year <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
				20f. (City or town) <u></u> (County) <u></u> (State) <u></u>			
21. I certify that I attended the deceased from <u>Oct 21</u> , 19 <u>59</u> , to <u>Feb 27</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>Feb 12</u> , 19 <u>62</u> , and that death occurred at <u>7:45 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Philip E. Jones</u> M.D.				ADDRESS (Street, city or town, state) <u>918 Ellsworth Drive</u> DATE SIGNED <u></u>			
PHYSICIAN'S NAME (Type) <u>Philip E. Jones</u>				<u>Silver Spring Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/2/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemerery</u>		22d. LOCATION (City, town, or county) <u>Silver Spring, Maryland</u> (State) <u></u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>DATE MAR 2 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)  
ISM 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02159					02142						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)						
a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			a. STATE		b. COUNTY				
MONTGOMERY		MARYLAND			MARYLAND		MONTGOMERY				
c. LENGTH OF STAY IN 1b		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
OLNEY		7 DAYS			X OLNEY						
MONTGOMERY GENERAL HOSPITAL											
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH						
First Middle Last					Month Day Year						
HAZEL ELIZABETH SWANN					2-18-62 19						
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)			
FEMALE		COLORED		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7-8-16		45 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
HOUSEWIFE							MARYLAND		U.S. A.		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
WILLIAM GAINES					MARGARET BROWN						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.		17. INFORMANT			Address	
							HOSPITAL RECORDS				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 446X IMMEDIATE CAUSE (a) Renal Shutdown - Nephrosclerosis DUE TO and Severe Arteriosclerotic Heart Disease c Aortic Stenosis (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 1-18-62 to 1955, that (I) (we) last saw the deceased alive on 1-18-62, and that death occurred at 3:40A M, from the causes and on the date stated above. 22a. SIGNATURE Richard A. Yates M.D. 22b. DATE SIGNED 2-19-62 22c. PHYSICIAN'S NAME (Type) RICHARD A. YATES, M.D. 22d. ADDRESS OLNEY, MARYLAND 23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 2/22/62 23c. NAME OF CEMETERY OR CREMATORY Carver Memorial Park., 23d. LOCATION (City, town or county) (State) Laurel, Md. 24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden ADDRESS Rockville, Md. 25a. REC'D BY REGISTRAR DATE FEB 21 1962 25b. REGISTRAR'S SIGNATURE Arthur L. Evans											

US413

CERTIFICATE OF DEATH

02128

M

FOOTPRINT

HANDPRINT

FOOTPRINT

CLIMBY

17 DAYS

CLIMBY

HOSPITAL GENERAL HOSPITAL

2-1-18

SHARP

CLIMBY

1822

18

5-1-18

COLORED

TEMPLE

U.S.A.

ADLAND

HOSPITAL

HOSPITAL RECORD

ALLAN JAMES

HOSPITAL RECORD

CLIMBY, MAYLON

CLIMBY, MAYLON

CLIMBY, MAYLON

CLIMBY, MAYLON

CLIMBY, MAYLON

CLIMBY, MAYLON



## CERTIFICATE OF DEATH

Reg. Dist. No. 02143

02160

## 1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

## 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

D.C.

b. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Sakoma Park

c. LENGTH OF STAY IN 1b

3yr. 4mth

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Washington

47X-3

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Cedar Haven Rest Home

d. STREET ADDRESS

1343 Irving St. NW

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☐

## 3. NAME OF DECEASED (Type or print)

First MARY EMMA

Middle

MOLTZ

Last

SWANN

## 4. DATE OF DEATH

Month

Feb.

Day

13

Year

1962

## 5. SEX

Female

## 6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

## 8. DATE OF BIRTH

Oct. 15, 1869

## 9. AGE (In years last birthday)

92 yrs.

## IF UNDER 1 YEAR

Months

Days

Hours

Min.

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Bn. engraving

## 10b. KIND OF BUSINESS OR INDUSTRY

U.S. Government

## 11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

Henry Maltz

## 14. MOTHER'S MAIDEN NAME

Eugia Leach

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

No

## 16. SOCIAL SECURITY NO.

## INFORMANT

Charles A. Swann 309 Riley N. Falls Church Va.

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

## PART I. DEATH WAS CAUSED BY:

## IMMEDIATE CAUSE (a)

DUE TO

Cerebral hemorrhage

## INTERVAL BETWEEN ONSET AND DEATH

2 da

422-1  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

cardio vascular disease

3 yrs.

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

## 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

## 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

## 20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from June 1945 to Feb. 13, 1962 that I last saw the deceased alive on Feb. 13, 1962, and that death occurred at 11:00 P.M. from the causes and on the date stated above.

## ACTUAL SIGNATURE

E.F. Quayle

M.D.

ADDRESS (Street, city or town, state) 1822 Baltimore St. NW

## DATE SIGNED

2-13-62

## PHYSICIAN'S NAME (Type)

E.F. Quayle

Washington

D.C.

## 22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

## 22b. DATE THEREOF

Feb. 16, 1962

## 22c. NAME OF CEMETERY OR CREMATORY

Greenmont Cemetery

## 22d. LOCATION (City, town, or county)

Baltimore

(State)

Maryland

## 23. FUNERAL DIRECTOR'S SIGNATURE

## ADDRESS

J. Arthur Walters, 254 Carroll N.W. DC

## 24a. REC'D BY REGISTRAR

DATE FEB 16 '62

## 24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

02161

CERTIFICATE OF DEATH

02144

1. PLACE OF DEATH a. County <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wheaton Nursing Home, Wheaton, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>32 Silver Spring</b> d. STREET ADDRESS <b>1302 Caddington Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>-</b> Last <b>Tansky</b>		4. DATE OF DEATH Month <b>FEB</b> Day <b>19</b> Year <b>1962</b>	
5. SEX <b>FE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/12/92</b>
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HW</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>America</b>	
13. FATHER'S NAME <b>Konansky</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Leo Tansky</b>		Address <b>1302 Caddington Ave., SSpg., Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b> DUE TO <b>Thecal cell Carcinoma of Ovary</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. DUE TO (b) <b>2 years</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cardiac Failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 Months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>DEC. 1</b> 19 <b>61</b> to <b>Feb. 18</b> 19 <b>62</b> that (I) (we) last saw the deceased alive on <b>Feb. 18</b> 19 <b>62</b> , and that death occurred at <b>7:25 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>William Frank</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>WILLIAM FRANK, M.D.</b>		22d. ADDRESS <b>544 W. MONTGOMERY, ROCKVILLE, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb 20, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hebron Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Flushing, L.I., N.Y.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Stephen J. ...</b>		24b. ADDRESS <b>4217 9th St. N.W.</b>	
25a. REC'D BY REGISTRAR <b>DATE FEB 20 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Stephen J. ...</b>	

1915

CERTIFICATE OF BIRTH

1915



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

<p>1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San + Hospital</u></p>												<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u> d. STREET ADDRESS <u>13217 Andrew Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>											
<p>3. NAME OF DECEASED (Type or print) <u>Kimberly Gaye Teketch</u></p>												<p>4. DATE OF DEATH Month <u>2</u> Day <u>15</u> Year <u>1962</u></p>											
<p>5. SEX <u>Female</u></p>												<p>6. COLOR OR RACE <u>White</u></p>											
<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>												<p>8. DATE OF BIRTH <u>12-6-1960</u></p>											
<p>9. AGE (In years last birthday) <u>1</u> yrs.</p>												<p>IF UNDER 1 YEAR Months <u>1</u> Days <u>15</u> Hours <u>15</u> Min. <u>15</u></p>											
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u></p>												<p>10b. KIND OF BUSINESS OR INDUSTRY <u>None</u></p>											
<p>11. BIRTHPLACE (State or foreign country) <u>Takoma Park, Maryland</u></p>												<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>											
<p>13. FATHER'S NAME <u>James Edward Teketch</u></p>												<p>14. MOTHER'S MAIDEN NAME <u>Dorothy Smith</u></p>											
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)</p>												<p>16. SOCIAL SECURITY NO. <u>NONE</u></p>											
<p>17. INFORMANT <u>James E. Teketch</u> Address <u>13,217 Andrew Dr. Silver Spring Md.</u></p>																							
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>475X</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Upper Respiratory Infection</u> DUE TO (c) <u>2 days</u></p>												<p>INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u></p>											
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p>												<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>											
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/></p>												<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>											
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.</p>												<p>20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/></p>											
<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>												<p>20f. (City or town) (County) (State)</p>											
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>																							
<p>ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.</p>												<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/></p>											
<p>EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u></p>												<p>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p>											
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>												<p>22b. DATE THEREOF <u>2-19-62</u></p>											
<p>22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u></p>												<p>22d. LOCATION (City, town, or country) (State) <u>Prince George's Co. Maryland</u></p>											
<p>23. FUNERAL DIRECTOR <u>Raymond A. Ziska</u> Address <u>8434 Georgia Ave.</u></p>												<p>24a. REC'D BY REGISTRAR <u>FEB 21 '62</u></p>											
<p>24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u></p>																							

05145

05145

(M)

(1)

James E. Taylor, Jr.

James

James

James E. Taylor, Jr.

James E. Taylor, Jr.

James E. Taylor, Jr.

James

James

James E. Taylor, Jr.

James E. Taylor, Jr.

James E. Taylor, Jr.

James E. Taylor, Jr.

James E. Taylor, Jr.

James E. Taylor, Jr.

James E. Taylor, Jr.

James E. Taylor, Jr.

James E. Taylor, Jr.



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

I

2

2

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02163 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02146									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>60</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			d. STREET ADDRESS <u>7737 Bradley Blvd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7737 Bradley Blvd</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Monica</u> First <u>Temp</u> Middle Last					4. DATE OF DEATH <u>February 21, 1962</u> Month Day Year				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/13/62</u>		9. AGE (In years last birthday) yrs. <u>1</u> Months <u>8</u> Days <u>8</u> Hours <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Siegfried K. Temp</u>					14. MOTHER'S MAIDEN NAME <u>Margot Huberti</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Siegfried Temp-father-same above</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>491X</u> IMMEDIATE CAUSE (a) <u>Bilateral Confluent Bronchial Pneumonia</u> DUE TO (b) <u>in bed</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>found dead</u>								INTERVAL BETWEEN ONSET AND DEATH <u>found dead</u> <u>in bed</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
					DATE SIGNED <u>February 21, 1962</u>				
					Address (Street, city, town, or county)				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/23/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Arlington, Virginia</u>			
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Maryland</u> ADDRESS					24a. REC'D BY REGISTRAR <u>MAR 1 '62</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

2074263155

02183

(M)

Report of Submarine, Hawaiian Islands, 1941-1942  
Submarine, Hawaiian Islands, 1941-1942  
Submarine, Hawaiian Islands, 1941-1942

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02164

## CERTIFICATE OF DEATH

02147

<b>1. PLACE OF DEATH</b> a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> c. LENGTH OF STAY IN lb <b>7HR. 55MIN.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>FLEMING</b> <b>TERRY</b>		<b>4. DATE OF DEATH</b> Month <b>2</b> Day <b>19</b> Year <b>62</b>					
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>COLORED</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>8-5-06</b>	<b>9. AGE</b> (In years last birthday) <b>55</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>VIRGINIA</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>EDDIE TERRY</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>LULA TERRY</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address			
<b>HOSPITAL RECORDS</b>							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>526X</b> DUE TO <b>Acute Pericarditis</b> <b>526X</b> DUE TO <b>Lobar Pneumonia</b> <b>526X</b> DUE TO <b>Chronic Bilateral Bronchiectasis</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>4-6 days.</b> <b>4-6 days.</b> <b>years.</b>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify medical examiner)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>19</b> e.m. p.m.		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Oct 1:25A</b> <b>1961</b> <b>to</b> <b>Feb 1962</b> <b>that (I) (we) last saw the deceased alive on</b> <b>2-18-62</b> <b>19</b> , and that death occurred at <b>1:25A</b> <b>M</b> , from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <b>Richard A. Yates, M.D.</b>		<b>22b. DATE SIGNED</b>		<b>22c. PHYSICIAN'S NAME</b> (Type) <b>RICHARD A. YATES, M.D.</b>			
<b>22d. ADDRESS</b>		<b>22e. ADDRESS</b> <b>OLNEY, MARYLAND</b>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)		<b>23b. DATE THEREOF</b> <b>2/23/62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Ash Memorial.</b>			
<b>23d. LOCATION</b> (City, town or county) <b>Sandy Spring, Md.</b>		<b>23e. LOCATION</b> (City, town or county) (State)					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Robert L. Snowden</b>		<b>24b. ADDRESS</b> <b>Rockville, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>FEB 21 '62</b>			
<b>25b. REGISTRAR'S SIGNATURE</b>							

USIA

CONFIDENTIAL NO. 1000

00000

M

1

NAME: COLORED  
AGE: 22  
SEX: MALE  
RACE: COLORED  
DATE: 10-10-62  
TIME: 10:00 AM  
PLACE: 1000

COLORED

COLORED

1000

COLORED

RICHARD J. YATES, JR.

COLORED

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1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02165

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02148

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>25 min</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>45 Bethesda</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Sanitarium + Hosp.</i>				d. STREET ADDRESS <i>5700 Anniston Rd</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>David Turnbull Thomas</i>				4. DATE OF DEATH Month Day Year <i>2 12 1962</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-26-07</i>	9. AGE (In years last birthday) <i>54 yrs.</i>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Chemical</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S A.</i>	
13. FATHER'S NAME <i>William H. Thomas</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Turnbull</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-09-0946</i>		17. INFORMANT (Sister) Address <i>University Park Md. 6406 40th Ave</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>History of previous coronary disease</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>2-12-62</i>							
ACTUAL SIGNATURE <i>Frank J. Broschant</i>		M.D.		DATE SIGNED <i>2-12-62</i>			
EXAMINER'S NAME (Type) <i>FRANK J. BROSCHANT</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2/15/62</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		22d. LOCATION (City, town, or country) <i>Rockville, Maryland</i>			
23. FUNERAL DIRECTOR <i>Robert A. Pumphrey, Bethesda, Maryland</i>				24a. REC'D BY REGISTRAR DATE <i>FEB 15 '62</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

MEDICAL CERTIFICATION

05207



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The physician may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																	
02166						02149											
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)											
a. COUNTY			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			a. STATE			b. COUNTY								
MONTGOMERY			MARYLAND			MARYLAND			MONTGOMERY								
c. LENGTH OF STAY IN 1b			d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS								
15 DAYS			MONTGOMERY GENERAL HOSPITAL			X SILVER SPRING			Box 273 Good Hope Road								
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>								
JAMES ROBERT THOMAS						2 22 19 62											
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR							
MALE		COLORED		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		6-14-81		80 yrs.		Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)									
								MARYLAND									
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?									
WILLIAM THOMAS				SARAH MOSBY				U. S. A.									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT Address									
								HOSPITAL RECORDS									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)																	
460X DUE TO PULMONARY Emboli																	
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) VARICOSE VEINS (LEG bilateral)																	
(c) DUE TO HYPERTENSIVE HEART DISEASE																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19										20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)							
21. I certify that (I) <del>this has been</del> attended the deceased from January 1961, to 2/22 1962 that (I) <del>was</del> last saw the deceased alive on 2/22 1962 and that death occurred at 8:40 A.M. from the causes and on the date stated above.																	
22a. SIGNATURE										22b. DATE SIGNED							
John P. Martin M.D.										2/22							
22c. PHYSICIAN'S NAME (Type)										22d. ADDRESS							
JOHN P. MARTIN, M.D.										SANDY SPRING, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify)												23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
Burial												2-26-62		Round Oak Cem.		Spencerville, Md	
24. FUNERAL DIRECTOR'S SIGNATURE										ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Robert L. Snowden										Rockville, Md.		DATE FEB 27 '62		Arthur S. Kraus			

02113

02162



MONTGOMERY

MARYLAND

MONTGOMERY

JOHN P. MARTIN

12 DAYS

1944

CLERY

100-125 (See Home Box)

MONTGOMERY GENERAL HOSPITAL

53

53

2

THOMAS

ROBERT

JAMES

COLEMAN

DATE

80

2-11-44

100-125

WILLIAM THOMAS

SATAN MESSY

HOSPITAL RECORDS

JOHN P. MARTIN (100-125)

WILLIAM THOMAS (100-125)

JAMES P. MARTIN, MARYLAND

JOHN P. MARTIN, MARYLAND

100-125

100-125

2-11-44

CLERY

100-125

100-125

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

02167

02150

1. PLACE OF DEATH o. COUNTY <b>Nontgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>				c. LENGTH OF STAY IN 1b <b>6 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oella</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Asbury Methodist Home for Aged Inc</b>				d. STREET ADDRESS <b>x</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Wesley</b> Last <b>TICE</b>				4. DATE OF DEATH Month <b>Feb</b> Day <b>19</b> Year <b>1962</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 9, 1868</b>	
9. AGE (In years last birthday) <b>93</b> yrs.		IF UNDER 1 YEAR Months <b>03</b> Days <b>x</b> Hours <b>2</b>		IF UNDER 24 HRS. Hours <b>00</b> Min. <b>00</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>packing &amp; shipping</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Phillips Bros. Balto</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>William Henry Tice</b>				14. MOTHER'S MAIDEN NAME <b>Eliza Stewart</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>212 20 7081</b>		17. INFORMANT <b>records of Asbury Home, Gaithersburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Several years</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of Prostate</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>11-10</b> , 19 <b>60</b> , to <b>2-19</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>2-18</b> , 19 <b>62</b> , and that death occurred at <b>10:45 P</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>James W. Egan</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>James W. Egan</b>				22d. ADDRESS <b>7720 Wisconsin Ave. - Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-22-1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Good Shepherd</b>		23d. LOCATION (City, town, or county) (State) <b>Ellicott City, Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F.C.Higinbotham, Ellicott City, Md</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 21 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02168

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02151

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>41 Silver Spring</u>	
c. LENGTH OF STAY in 1b <u>12 yrs</u>		d. STREET ADDRESS <u>9832 Capital View Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>9832 Capital View Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James Henry Tillson</u>		4. DATE OF DEATH <u>Feb 3 1962</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 29, 1899</u>	
9. AGE (in years last birthday) <u>62 yrs.</u>		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Navy</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Mass</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Tillson</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WW I &amp; II</u>		16. SOCIAL SECURITY NO. <u>YES</u>	
17. INFORMANT <u>Albert Anderson - Sten</u>		Address <u>  </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>3rd degree burn involving entire body -</u> DUE TO <u>House fire</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>  </u> DUE TO <u>  </u> (b) <u>  </u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>House fire at home -</u>	
20c. TIME OF INJURY Month, Day, Year <u>4:30 p.m. 2-3 1962</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) <u>Silver Spring monty md</u> (County) <u>  </u> (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Frank J. Brosch</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>2-3-62</u>	
Address (Street, city, town, or county) <u>  </u>		DATE SIGNED <u>  </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-7-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Suitland Prince Georges Co Md.</u>	
23. FUNERAL DIRECTOR <u>Raymond Q. Ziska</u> 8434 ADDRESS <u>Georgia Ave.</u>		24a. REC'D BY REGISTRAR <u>FEB 7 '62</u>	
Warner E. Pumphrey, Inc. Silver Spring, Md.		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

10150

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
02169						02152					
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>76 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Vienna</b> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Great Falls</b> d. STREET ADDRESS <b>Route # 1, Box 195</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>James Chester Tinkham</b>			4. DATE OF DEATH Month <b>February</b> Day <b>14</b> Year <b>19 62</b>			5. SEX <b>Male</b>			6. COLOR OR RACE <b>White</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>February 3, 1944</b>			9. AGE (In years last birthday) <b>18</b> yrs.			10. KIND OF BUSINESS OR INDUSTRY <b>Student</b>		
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>			11b. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Francis C. Tinkham</b>		
14. MOTHER'S MAIDEN NAME <b>Luella Schreiner</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>228-54-5212</b>			17. INFORMANT <b>The Medical Record</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Reticulum cell Sarcoma, generalized</b> DUE TO (b) _____ DUE TO (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>5 months</b>			20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>November 30, 1961</b> to <b>February 14, 1962</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>February 14, 1962</b> , and that death occurred at <b>4:00 AM</b> , from the causes and on the date stated above.			22a. SIGNATURE <b>Edward S. Henderson</b> M.D.			22b. DATE SIGNED <b>February 14, 1962</b>			22c. PHYSICIAN'S NAME (Type) <b>Edward S. Henderson</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Feb 17 1962</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Nat. Memor. Park</b>			23d. LOCATION (City, town or county) (State) <b>Falls Church, Va.</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Pearson Funeral Home</b>			24b. ADDRESS <b>Falls Church, Va</b>			25a. REC'D BY REGISTRAR <b>Arthur S. Hanna</b>			25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>		

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The Clinical Center, Bethesda, Md.  
 Room 3, Box 100  
 Great Falls  
 Virginia  
 Washington, D.C.  
 February 2, 1966  
 James  
 Doctor  
 Clinician  
 February 2, 1966  
 U.S.A.

November 30, 1965  
 February 11, 1966  
 The Clinical Center, National  
 Institutes of Health, Bethesda, Md.  
 February 11, 1966

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02170

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02153

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY in 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		d. STREET ADDRESS <b>8316 Carey Lane</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Leonard</b> Last <b>Tippett</b>				4. DATE OF DEATH Month <b>February</b> Day <b>28</b> Year <b>19 62</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 16, 1892</b>		9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months <b>70</b> Days <b>70</b>	IF UNDER 24 HRS. Hours <b>70</b> Min. <b>70</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Model Maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Delaware Water-Navy Dept. Basin</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Leonard Tippett</b>				14. MOTHER'S MAIDEN NAME <b>Mary J. FitzGerald</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>579-18-5389</b>		17. INFORMANT <b>Katherine Diack Tippett</b> Address <b>8316 Carey Lane, S.S., Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Insufficiency</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Rupture of Atheromatous Plaque</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>February 28, 1962</b> Address (Street, city, town, or county)							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-3-62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Prince Georges County, Maryland</b>	
23. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc.</b>		ADDRESS <b>Raymond A. Ziska 8434 Georgia Ave Silver Spring, Md.</b>		24a. REC'D BY REGISTRAR <b>MAR 2 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

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James E. Rutherford, Inc., Silver Spring, Md.  
1000 North Carolina Avenue  
Silver Spring, Maryland

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02154

Weight 12g 02171

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>2 MINUTES</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>33 Rockville</u> d. STREET ADDRESS <u>1 4804 ASPEN HILL Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <u>BABY</u> Middle <u>GIRL</u> Last <u>TITUS</u>				<b>4. DATE OF DEATH</b> Month <u>FEBRUARY</u> Day <u>4</u> Year <u>1962</u>					
5. SEX <u>FEMALE</u>		6. COLOR OF RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEBRUARY 4, 1962</u>		9. AGE (In years last birthday) <u>—</u> yrs. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> IF UNDER 24 HRS. Hours <u>—</u> Min. <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NORMAN FRANKLIN TITUS</u>				14. MOTHER'S MAIDEN NAME <u>ETHEL ANN DIXON</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>FATHER</u> Address <u>—</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity 21 weeks</u> (b) <u>Premature rupture of Membrane</u> (c) <u>761.5</u> DUE TO <u>—</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u>—</u>								INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>—</u>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>					
20c. TIME OF INJURY Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>2/4</u> , 19 <u>62</u> , to <u>2/4</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>2/4</u> , 19 <u>62</u> , and that death occurred at <u>11:30</u> A.M. from the causes and on the date stated above.									
22a. SIGNATURE <u>Albert S Bright</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type or print) <u>ALBERT S BRIGHT MD</u>				22d. ADDRESS <u>8218 Wisconsin Ave Bethesda</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>2-4-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SUBURBAN HOSPITAL</u>		23d. LOCATION (City, town or county) (State) <u>BETHESDA, MARYLAND</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>AMELIA CARTER ADMIN. - SUBURBAN HOSPITAL</u> ADDRESS <u>BETHESDA, MD.</u>				25a. REC'D BY REGISTRAR <u>FEB 7 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

VR A15 (4)  
15M 9/60

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Photograph

Photograph

Portrait

Portrait

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4501 1900/10/10

Girl Titus

Girl Titus

Portrait

Portrait

4501 1900/10/10

Portrait of Frank Titus

Father

Father

4501 1900/10/10

4501 1900/10/10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Tken please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>3328 Runnymede Place, N. W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EULA</b> Middle <b>HAILE</b> Last <b>UNDERWOOD</b>		4. DATE OF DEATH Month <b>FEB</b> Day <b>6</b> Year <b>1962</b>	
5. SEX <b>FE</b>	6. COLOR OR RACE <b>WH</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-17-84</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Felix Haile</b>		14. MOTHER'S MAIDEN NAME <b>Prudence (Unknown)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Mrs. Ralph McDowell-daughter- Same</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION - HEART BLOCK</b> 4200 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) <b>CORONARY ARTERY DISEASE</b> DUE TO (c) <b>ARTERIO SCLEROSIS, generalized</b> INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b> <b>2 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 13, 1960</b> to <b>Feb 5, 1962</b> that (I) (we) last saw the deceased alive on <b>Feb 5, 1962</b> and that death occurred at <b>1:40 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert G. Taylor</b> M.D.		22b. DATE SIGNED <b>Feb 6, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>ROBERT G. TAYLOR</b>		22d. ADDRESS <b>WASHINGTON CLINIC, WASH. 15, D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit 2/8/62</b>		23b. DATE THEREOF <b>2/8/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Haile Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Jonesville, South Carolina</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>FEB 9 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thune</b>			

05135

05135

(M)

WASH DC

WASH DC

Suburban Hospital

For Mr. [illegible]

4-17-84

South Carolina

South Carolina

(Unlabeled)

(Unlabeled)

Mr. Ralph [illegible] - daughter - [illegible]

No

Mr. [illegible] - [illegible] - [illegible]

Community [illegible]

Mr. [illegible] - [illegible]

X

Mr. [illegible] - [illegible]

Mr. [illegible] - [illegible]

Robert P. Taylor

Robert P. Taylor

Robert A. [illegible] - [illegible]

South Carolina

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02173

## CERTIFICATE OF DEATH

02156

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN <u>19 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Gen &amp; Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> d. STREET ADDRESS <u>5130 Connecticut Ave., N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Dr. Arthur Thomas Utz</u>				4. DATE OF DEATH Month Day Year <u>2 25 1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-13-75</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dentistry</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>David E. Utz</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Myers</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service) <u>---</u>				16. SOCIAL SECURITY NO. <u>579-52-3902A</u>		17. INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>586X</u> DUE TO <u>Submucous Embolism following Cholecystectomy for gall stone infection</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Cholecystectomy for gall stone infection</u> DUE TO (c) <u>Cholecystectomy for gall stone infection</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Cholecystectomy for gall stone infection</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-7</u> , <u>1962</u> to <u>2-25</u> , <u>1962</u> that (I) (we) last saw the deceased alive on <u>2-24</u> , <u>1962</u> , and that death occurred at <u>8:15</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Chas H. Wolochon</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/25/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Chas H. Wolochon</u>				22d. ADDRESS <u>7607 Carroll Ave</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 28, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne E. Pamphrey, inc.</u> ADDRESS <u>Silver Spring, Md.</u>				25a. REC'D BY REGISTRAR <u>WAR 1 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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08133



James E. Jackson, Inc.  
Silver Spring, Md.  
Feb. 26, 1963 Richmond Cemetery  
Landis, 200, D.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02157

02174

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN It <u>13 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>		e. STREET ADDRESS <u>1605 Philadelphia Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Emmett Guy Vannoy</u>		4. DATE OF DEATH Month <u>2</u> - Day <u>15</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-14-95</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Intelligence Analyst U.S. Army Corp</u>		11. BIRTHPLACE (County & State, or foreign country) <u>W. Va</u>	
13. FATHER'S NAME <u>George Vannoy</u>		14. MOTHER'S MAIDEN NAME <u>Della Bush</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>National Guard</u>		16. SOCIAL SECURITY NO. <u>wife</u>	
17. INFORMANT <u>same</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia &amp; Emaciation</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>metastases to bones</u> (c) <u>Carcinoma of Prostate</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>9 months</u> <u>6 1/2 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>February, 1961</u> to <u>2-15, 1962</u> , that (I) (we) last saw the deceased alive on <u>2-15-1962</u> , and that death occurred <u>at 1:25 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Norman C. Shoemaker M.D.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Norman C. SHOEMAKER, M.D.</u>		22d. ADDRESS <u>8005 Woodbury Dr. Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Sellers</u>		25. REC'D BY REGISTRAR DATE <u>FEB 19 '62</u>	
25. REGISTRAR'S SIGNATURE <u>Arthur S. Sellers</u>			

05125

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

02175

CERTIFICATE OF DEATH

02158

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Garrett Park</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Garrett Park</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>10937 Montrose Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>IDA</b>		First <b>HOUGHTON</b> Middle <b>VanTROTSEN</b> Last <b>BURG</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>7,</b> Year <b>19 62</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 23, 1870</b>		9. AGE (In years last birthday) <b>91</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William Jackson Houghton</b>				14. MOTHER'S MAIDEN NAME <b>Annie Elizabeth Fogg</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Neice Mrs. Richard Dupree</b>		Address <b>Same as Item 2.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion Aorta</b> DUE TO <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Senility - (age 91)</b> (c) <b>Upper Respiratory Infection (f nmk)</b>						INTERVAL BETWEEN ONSET AND DEATH <b>acute (Ar.)</b> <b>yrs.</b> <b>yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Upper Respiratory Infection (f nmk)</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>1955</b> 19 to <b>2/7/62</b> 19, that (I) (we) last saw the deceased alive on <b>2/6/62</b> 19, and that death occurred at <b>6 A.M.</b> from the causes and on the date stated above.		22a. SIGNATURE <b>SAM Allen</b> 22b. PHYSICIAN'S NAME (Type) <b>SAM ALLEN, M.D.</b> <b>Remington, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-10-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Remington Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Remington, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>				25a. REC'D BY REGISTRAR <b>FEB 9 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

MEDICAL CERTIFICATION

02153

CRIMINAL CASE NO. 10053

02153

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10053 MONROE AVE.

10053 MONROE AVE.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

Item 18 Film 307 2-21-62											
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02176						02159					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			a. STATE			b. COUNTY		
Montgomery			Bethesda			Md.			Mont. Co.		
c. LENGTH OF STAY IN 1b			d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS		
2 days			Seaboard			Rockville			603-McIntyre Rd.		
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
Kenneth C. Walters						Feb. 8 1962					
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
male		white		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5/21/24		37 yrs.		Months 9 Days 6 Hours Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Production engineer Engineering						Pennsylvania		U. S. A.			
13. FATHER'S NAME						14. MOTHER'S M maiden NAME					
William R. Walters						Martha S. Robinson					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)						16. SOCIAL SECURITY NO.					
yes. Army - World War II 4656						74-12-1000					
17. INFORMANT						Address					
Robert M. Walters						100-W. Diamond					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)											
178X DUE TO Respiratory failure											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary metastasis											
(c) Carcinoma of the testis											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
Interval between ONSET AND DEATH											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19											
21. I certify that (I) (this hospital) attended the deceased from Jan 15, 1962 to Feb 8, 1962 that (I) (we) last saw the deceased alive on Jan 8, 1962, and that death occurred at 3:00 PM from the causes and on the date stated above.											
22a. SIGNATURE						22b. DATE SIGNED					
William R. Walters						Feb 13 '62					
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
H Killay						8275 Wisconsin Ave					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town or county) (State)	
Burial				2/10/1962		Parklawn				Rockville Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE						25a. REC'D BY REGISTRAR					
Robert A. Pumphrey Bethesda, Maryland						Feb 13 '62					
						25b. REGISTRAR'S SIGNATURE					
						C. L. H. H. H.					

05130

05130



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*[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page.]*

Robert A. Humphrey, Bethesda, Maryland  
Hockville, Maryland

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

<div>Item 18 Film 307 2-26-62</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>02177 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02160</div>											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY in 1b <u>D.O.A</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>Route # 3</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Jeffery Lynn Webb</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>10</u> Year <u>1962</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/4/61</u>		9. AGE (In years last birthday) yrs. <u>3</u> Months <u>6</u> Days <u>6</u>		10. IF UNDER 1 YEAR Hours <u>6</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Ernest Simon Webb</u>				14. MOTHER'S MAIDEN NAME <u>Ila Faye Temple</u>				Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT <u>Mother same as above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital heart disease</u> <u>754.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Interventricular septal defect</u> (e), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilateral inguinal hernia operation 2-6-62</u>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Brochart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>Feb 10-62</u>			
EXAMINER'S NAME (Type) <u>Frank J. Brochart</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>2-12-62</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Laytonsville</u>			
22d. LOCATION (City, town, or country) <u>Laytonsville, Maryland</u>				22e. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE <u>Charles E. Hines</u>			
23. FUNERAL DIRECTOR <u>Francis W. Barber</u>				ADDRESS <u>Laytonsville, Md.</u>				DATE <u>FEB 14 '62</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02178

02161

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>Suburban</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>--</b> b. COUNTY <b>--</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, DC</b> d. STREET ADDRESS <b>4500-Newark Street NW</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Edythe</b> Middle <b>Weed</b> Last <b>Feb</b>				<b>4. DATE OF DEATH</b> Month <b>21</b> Day <b>19</b> Year <b>62</b>			
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>July 16 1882 79</b>	
<b>9. AGE</b> (In years last birthday) <b>79</b> yrs.		<b>IF UNDER 1 YEAR</b> Months <b>Days</b>		<b>IF UNDER 24 HRS.</b> Hours <b>Min.</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>At Home</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>At Home</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Hemlock Grove Ohio</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>	
<b>13. FATHER'S NAME</b> <b>David M. Nelson</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Marilee C. Shumway</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>—</b>		<b>17. INFORMANT</b> Address <b>E. R. Nelson 3121-16<sup>th</sup> St NW.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>260 X</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Diabetes Mellitus - Gen. Arteriosclerotic</b> <b>2 yr</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Duodenal Ulcer, Chn. Pyelonephritis (Prev 405)</b> <b>Nephrectomy</b>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from <u>1-6</u>, 19<u>62</u> to <u>Feb 21</u>, 19<u>62</u>, that (I) (we) last saw the deceased alive on <u>Feb 20</u>, 19<u>62</u>, and that death occurred at <u>11</u> M., from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>James E. Nolan</b> M.D.				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>2-21-62</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>James E. Nolan</b>				<b>22d. ADDRESS</b> <b>5401 Western Ave NW Wash DC.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>2/24/62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Rock Creek Cemetery</b>		<b>23d. LOCATION (City, town or county) (State)</b> <b>Washington, D.C.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>The S.H. Hines Co., 2901 14th St. N.W.,</b>				<b>25a. REC'D BY REGISTRAR</b> <b>DATE FEB 23 '62</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hanna</b>	

02181

02181

Washington, DC

Seaside

1500-Keweenaw Street NW

Seaside

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52

52

Wood

Edythe

Willa

Romana

Al. Home

James E. Nolan

James E. Nolan

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James E. Nolan

James E. Nolan

The S. M. Jones Co., 2201 1st St. N.W.

## CERTIFICATE OF DEATH

Reg. Dist. No. 02162

02179

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>6 MO</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>10102 KINROSS AVENUE</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
3. NAME OF DECEASED (Type or print) <b>ELIZABETH MURCHY WEIR</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>7</b> Year <b>1962</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 24, 1880</b>
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>SCOTLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN HYSLOP</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH IRVING IRVINE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>DAUGHTER</b>		Address <b>MARGARET WARE - 10102 KINROSS AVE SS. Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS</b> DUE TO <b>170X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARCINOMA RIGHT BREAST</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b>			INTERVAL BETWEEN ONSET AND DEATH <b>22 Mo</b> <b>20 yrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>7-25</b> , 19 <b>61</b> , to <b>2-7-</b> , 19 <b>62</b> , that I last saw the deceased alive on <b>2-6-</b> , 19 <b>62</b> , and that death occurred at <b>1:20 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2-7-62</b> DATE SIGNED <b>Samuel A. Hillman</b> M.D. <b>8829 Flower Ave. Silver Spring</b>			
ACTUAL SIGNATURE <b>Samuel A. Hillman</b> M.D. <b>8829 Flower Ave. Silver Spring</b>			
PHYSICIAN'S NAME (Type) <b>SAMUEL A. Hillman</b> <b>MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-10-62</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Wollaston Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Quincy Norfolk Co., Massachusetts</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Pumphrey, Inc.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 9 '62</b>	24b. REGISTRAR'S SIGNATURE <b>Wm. S. Pumphrey</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar's office to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02180

02163

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>7611 Whittier Blvd.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>ROBERT A. WELLS</b>			4. DATE OF DEATH Month <b>Feb.</b> Day <b>22</b> , Year <b>1962</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 19, 1905</b>		9. AGE (In years last birthday) <b>56</b> yrs. <b>8</b> Months <b>3</b> Days
10a. OCCUPATION (Give kind of work done during most of working life, or if retired) <b>Chief Info. Officer, Fish &amp; Wild Life Service</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. of Interior Gov't</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>			13. FATHER'S NAME <b>Stewart G. Wells</b>		
14. MOTHER'S MAIDEN NAME <b>Ida B. Starrin</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>075-07-6216</b>			17. INFORMANT <b>Wife Ethel P. Wells</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>CORONARY ARTERY DISEASE WITH ANGINA</b> DUE TO (c) <b>2 MC.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Bethesda</b>	(County) (State)
21. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>OCT. 1957</b> to <b>FEB. 22, 1962</b> that (I) <del>(we)</del> last saw the deceased alive on <b>FEB. 19, 1962</b> and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Leo M. Curtis</b>		22b. DATE SIGNED <b>2/22/62</b>		22c. PHYSICIAN'S NAME (Type) <b>LEO M. CURTIS</b>	
22d. ADDRESS <b>8218 Wisconsin Ave., Bethesda, Md.</b>		22e. ADDRESS <b>8218 Wisconsin Ave., Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 2-25-62</b>		23b. DATE THEREOF <b>2-25-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bethlehem Cemetery</b>	
23d. LOCATION (City, town or county) <b>Delmar, New York</b>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		ADDRESS <b>Bethesda, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 1 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Carlton S. Kraus</b>					





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02181

## CERTIFICATE OF DEATH

02164

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> c. LENGTH OF STAY in 1b <i>1-12-62</i> <i>2-8-62</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Washington Sanitarium &amp; Hospital</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> <i>16 52-2</i> d. STREET ADDRESS <i>6807 Bedford Drive</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mrs Annie Maria Wheeler</i>		4. DATE OF DEATH Month Day Year <i>Feb 8 1962</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-20-88</i>
9. AGE (In years last birthday) <i>73</i> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at Home</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore, Md.</i>
12. CITIZEN OF WHAT COUNTRY <i>U.S.</i>		13. FATHER'S NAME <i>Thomas Wheeler</i>	
14. MOTHER'S MAIDEN NAME <i>Mary Hendrix</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>	
16. SOCIAL SECURITY NO. <i>Washington San &amp; Hospital records.</i>		17. INFORMANT <i>Washington San &amp; Hospital records.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma to liver &amp;</i> <i>153.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>body in operation.</i> (a), stating the underlying cause last. DUE TO (c) <i>Carcinoma Cecum</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Feb. 1, 1962</i> to <i>Feb. 8, 1962</i> that (I) (we) last saw the deceased alive on <i>Feb 8, 1962</i> and that death occurred at <i>2 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>J. B. Barr, MD</i>		22b. DATE SIGNED <i>Feb 13 '62</i>	
22c. PHYSICIAN'S NAME (Type) <i>J. B. BARR, MD</i>		22d. ADDRESS <i>4500 College Ave, College Park, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Feb 10, 1962</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Methodist Protestant Cemetery</i>	23d. LOCATION (City, town or county) (State) <i>Two Market - Md. Line Maryland</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur Walters</i>		25a. REC'D BY REGISTRAR <i>Feb 13 '62</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>		25c. DATE <i>Feb 13 '62</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

LaUSD

4250

## CERTIFICATE OF DEATH

Reg. Dist. No. 02165

02182

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>2 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9406 Garwood Street</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>22 Silver Spring,</b>	
f. STREET ADDRESS <b>9406 Garwood Street</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Eleanor</b> Middle <b>HARVEY</b> Last <b>Whitcroft</b>		4. DATE OF DEATH Month <b>February</b> Day <b>5th</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 11th, 1905</b>
9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months <b>56</b> Days <b>56</b> Hours <b>56</b> Min. <b>56</b>	IF UNDER 24 HRS. Months <b>56</b> Days <b>56</b> Hours <b>56</b> Min. <b>56</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Procurement Analyst</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>D.C. School Board</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Walter Harvey</b>		14. MOTHER'S MAIDEN NAME <b>Eleanor Bagger</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Richard P. Whitcroft, 9406 Garwood St. Sil.Sp.Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of both breasts with metastases</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>170X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>19</b> a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>February 1961</b> to <b>February 5, 1962</b> , that I last saw the deceased alive on <b>February 5, 1962</b> , and that death occurred at <b>8:45 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Bennet A. Porter, Jr., M.D.</b>		ADDRESS (Street, city or town, state) <b>9301 Colesville Rd., Silver Spring Md.</b>	
PHYSICIAN'S NAME (Type) <b>Bennet A. Porter, Jr., M.D.</b>		DATE SIGNED <b>Feb. 5, 1962</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/8/1962</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers, Inc. Silver Spring, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 9 '62</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

*Dr. Brockert Notified*

*Dr. Brockert Notified*

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>8 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>07 Gaithersburg</u>		d. STREET ADDRESS <u>116 Rolling Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Charles</u> Middle <u>L.</u> Last <u>White</u>				<b>4. DATE OF DEATH</b> Month <u>February</u> Day <u>13</u> Year <u>1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/13/17</u>	
9. AGE (In years last birthday) <u>44 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mailman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US Post Office</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>William Rodney White</u>			
14. MOTHER'S MAIDEN NAME <u>Mary E. Walker</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>yes</u> <u>WW 2</u>			
16. SOCIAL SECURITY NO. <u>220-09-9528</u>				17. INFORMANT <u>wife, Kate H. White</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>subarachnoid hemorrhage</u> DUE TO (b) <u>Ruptured intracranial aneurysm</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>14 hours</u> <u>14 hours</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-13-62</u> , <u>2-13</u> to <u>2-13</u> , 19 <u>62</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>2-13</u> , 19 <u>62</u> , and that death occurred at <u>9:30 A.M.</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Harvey H. Ammerman</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>Dr. Harvey Ammerman</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>2025 Eye St. N.W. D.C.</u>			
22b. DATE SIGNED <u>2-13-62</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb 17/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		23d. LOCATION (City, town or county) (State) <u>Gaithersburg Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edmund C. Gaithersburg</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 16 '62</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>							

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*Robert L. ...*  
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*Robert L. ...*

*Robert L. ...*



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02184

02167

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN (b) <b>1000 Daleview Drive</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Althea Woodland of Silver Spring</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) a. STATE <b>--</b> b. COUNTY <b>--</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b> d. STREET ADDRESS <b>1753 Kilbourne Place, N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>JOSEPHINE</b>		Last <b>WHITE</b>		<b>4. DATE OF DEATH</b> Month <b>2</b> Day <b>20</b> Year <b>1962</b>			
<b>5. SEX</b> <b>FEMALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <b>12/7/1873</b>		<b>9. AGE</b> (In years last birthday) <b>88</b> yrs.                 IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>TEACHER</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>SCHOOL</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>NEW YORK</b>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>				<b>13. FATHER'S NAME</b> <b>GEORGE WHITE</b>			
<b>14. MOTHER'S MAIDEN NAME</b> <b>KATHRYN LOWE</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>			
<b>16. SOCIAL SECURITY NO.</b> <b>none</b>		<b>17. INFORMANT</b> <b>Records at Nursing Home -- Same #1</b>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO (b) <b>332X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>332X</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>uremia. Intercerebral heart disease</b>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>21 July 1960</b> <b>to</b> <b>20 Feb 1962</b> <b>that (I) (we) last saw the deceased alive on</b> <b>19 Feb 1962</b> <b>and that death occurred at</b> <b>3 AM</b> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>Seruch T. Kimble</b>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22b. DATE SIGNED</b>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Seruch T. Kimble</b>				<b>22d. ADDRESS</b> <b>927 Pershing Drive, Silver Spring, Md.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Cremation</b>		<b>23b. DATE THEREOF</b> <b>2/22/62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Fort Lincoln Crematory Prince Georges County, Md.</b>			
<b>23d. LOCATION (City, town or county)</b> <b>Wash. DC</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE FEB 21 '62</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hines</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>The S.H.Hines Co.-2901 14th St., N.W.</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02185											
02168											
1. PLACE OF DEATH a. COUNTY MONTGOMERY COUNTY MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN Ib 2 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE				d. STREET ADDRESS Rt. 2, Box 164	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last CLARENCE LESLIE WILBURN						4. DATE OF DEATH Month Day Year FEBRUARY 10 1962					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-16-1983		9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED R.R.CONDUCTOR				10b. KIND OF BUSINESS OR INDUSTRY Western Md. R.R.				11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME WILLIAM WILBURN						14. MOTHER'S MAIDEN NAME MARY MARTHA BUCKALEW					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) UNKNOWN				16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT HOSPITAL RECORDS OLNEY, MARYLAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE GENERALIZED PERITONITIS DUE TO CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b) PERFORATED ULCERATED CARCINOMA (c) OF STOMACH PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that (I) (his hospital) attended the deceased from March 20, 1961, to 2-10, 1962 that (I) (we) last saw the deceased alive on 2-8, 1962, and that death occurred at 7:30 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Sani Okutman M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2-8-62			
22c. PHYSICIAN'S NAME (Type) A. SANI OKUTMAN, M. D.						22d. ADDRESS SYKESVILLE, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-13-62		23c. NAME OF CEMETERY OR CREMATORY Hill Crest		23d. LOCATION (City, town or county) Pumderland, Md.		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Haight						ADDRESS Sykesville, Md.		25a. REC'D BY REGISTRAR DATE FEB 15 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Haight	

(M)

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MONTGOMERY COUNTY

MARYLAND

APPROX

DAVEY

2 DAYS

UNRECORDED

MONTGOMERY GENERAL HOSPITAL

ST. JOSEPH'S

CLARENCE

LESLIE

WILSON

FEBRUARY 10

62

X

MALE WHITE

10-16-1883

78

RETIRED R.R. CONDUCTOR

-

WEST VIRGINIA

UNITED STATES

WILLIAM H. HUGHES

MARY MARYA DUGAN

UNKNOWN HOSPITAL RECORDS - ST. JOSEPH'S

WILLIAM H. HUGHES - 10-16-1883

WILLIAM H. HUGHES - 10-16-1883

WILLIAM H. HUGHES - 10-16-1883

WILLIAM H. HUGHES - 10-16-1883

WILLIAM H. HUGHES - 10-16-1883

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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MONTGOMERY  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02186  
02169  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington Sanitarium and Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>32 Silver Spring,</b> d. STREET ADDRESS <b>11507 Georgia Avenue,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) <b>Wilhelm</b>		4. DATE OF DEATH <b>February 18,</b> <b>19 62</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-18-62</b>		9. AGE (In years last birthday) <b>20</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>no</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>no</b>			
13. FATHER'S NAME <b>Sonny Gene Wilhelm</b>				14. MOTHER'S MAIDEN NAME <b>Helen Effie Price</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no no no</b>				16. SOCIAL SECURITY NO. <b>no</b>				17. INFORMANT <b>father</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> 762-5 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>asphyxia</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)														20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occurred at.....M, from the causes and on the date stated above.																					
22a. SIGNATURE <b>Herbert J. Friedel</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>Herbert J. Friedel, M. D.</b>														22b. DATE SIGNED <b>2/20/62</b>				22d. ADDRESS <b>6826 Riggs Rd., Hyattsville, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>				23b. DATE THEREOF <b>2-19-62</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Washington Sanitarium and Hospital, Takoma Park, Maryland</b>				23d. LOCATION (City, town or county) (State)									
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Hare, M. D. Wash. San. &amp; Hospital</b>														25a. REC'D BY REGISTRAR <b>1 '62</b>				25b. REGISTRAR'S SIGNATURE <b>Robert A. Hare</b>			

2275262153

02180

02180



Montgomery

Montgomery

Montgomery

James Earl

James Earl

Washington State Penitentiary and Hospital

1100 Georgia Avenue

February 20, 1962

William

20

2-10-62

Female

Mayland

no

no

price

price

Heisen

Wilhelm

Gene

only

father

no

no

no

Washington State

Penitentiary

6026 State St., Spokane, Washington

Spokane, Washington

Washington State Penitentiary and Hospital

2-10-62

William

Robert A. ... Washington State Penitentiary and Hospital



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# MONTGOMERY STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02187

## CERTIFICATE OF DEATH

02170

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> <b>1661-2</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Carroll Rest Home</b>				d. STREET ADDRESS <b>3825 Hamilton Street</b>			
3. NAME OF DECEASED (Type or print) <b>SUSIE</b> <b>WILKINSON</b>				4. DATE OF DEATH <b>Feb. 25 1962</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 22, 1878</b>	
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months <b>25</b> Days <b>19</b>		IF UNDER 24 HRS. Hours <b>19</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>England</b>	
12. CITIZEN OF WHAT COUNTRY? <b>England</b>							
13. FATHER'S NAME <b>Anthony Wilkinson</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Unk.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>579-24-6939</b>			
17. INFORMANT <b>Anthony Wilkinson Same as #2 (nephew)</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>443</b> IMMEDIATE CAUSE (a) <b>HYPERTENSIVE HEART DISEASE</b> DUE TO (b) <b>ESSENTIAL HYPERTENSION</b> DUE TO (c) <b>GENERALIZED ARTERIOSCLEROSIS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>SENILITY</b>				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>SEPT 22, 1961</b> , to <b>Feb. 25, 1962</b> that (I) (we) last saw the deceased alive on <b>Feb. 25, 1962</b> and that death occurred at <b>5 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Francis Gasch's Sons</b>				22b. DATE SIGNED <b>Feb. 25-1962</b>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/28/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		23d. LOCATION (City, town or county) (State) <b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis Gasch's Sons</b>				ADDRESS <b>Hyattsville, Maryland</b>		25a. REC'D BY REGISTRAR <b>MAR 1 '62</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

05170

02182



3823 Hamilton Street

Cherry Hill Home

Nov. 22, 1878

Female Wife

England

England

Own Home

Honolulu

Barb. Unit.

Anthony Wilkinson

575-24-005 Anthony Wilkinson Barre as 12 (nephew)

no

Md.

Colman Barre

Fr. Lincoln

Barre 2/23/02

Byttsville, Maryland

Francis Osch's Sons

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VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02188  
CERTIFICATE OF DEATH  
02171

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY in 1b <b>43 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>District Of Columbia</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>651 Jefferson Street, N.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <b>Carrie Elizabeth Williams</b>		4. DATE OF DEATH <b>February 13, 1962</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 26, 1928</b>		9. AGE (In years last birthday) <b>33</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bacteriologist</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Laboratory</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Ohio</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>George Tinley</b>				14. MOTHER'S MAIDEN NAME <b>Alma Johnson</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>Unascertainable</b>				17. INFORMANT <b>The Medical Records The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypotension and cerebral ischemia</b> DUE TO (b) <b>Cancer of the right breast</b> DUE TO (c) <b></b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>1 year</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)																19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>January 1, 1962</b> to <b>February 13, 1962</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>February 13, 1962</b> , and that death occurred <b>1:30 AM</b> from the causes and on the date stated above.																			
22a. SIGNATURE <b>Richard S. Rivlin</b>				22b. DATE SIGNED <b>February 13, 1962</b>				22c. PHYSICIAN'S NAME (Type) <b>Richard S. Rivlin</b>				22d. ADDRESS <b>The Clinical Center, National Institutes Of Health, Bethesda 14, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>2.18.62</b>				23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NAT'L. CEM. ARLINGTON, VIRGINIA</b>				23d. LOCATION (City, town or county) (State)							
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur L. Kline</b>				24b. ADDRESS <b>1820 9TH ST., WASHINGTON, D.C.</b>				25a. REC'D BY REGISTRAR <b>FEB 15 '62</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>							

08171

08171

Washington

Washington

13 days

501 Jefferson Avenue, N.Y.

Jefferson Ave., N.Y.

The Clinical Center,

February 13,

William

Elizabeth

Canada

November 20, 1958

Male Negro

U.S.A.

Ohio

Laboratory

Biotechnology

Alma Johnson

George T. May

The National Research

The Clinical Center, Jefferson Ave., N.Y.

Investigation in

the study of the clinical course of

the disease and the clinical course of

January 13, 1959

1:30 AM

February 13, 1959

The Clinical Center, National  
Institutes of Health, Bethesda, Md.

Robert A. Davis

U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE  
NATIONAL INSTITUTES OF HEALTH  
BETHESDA, MARYLAND 20892

WASHINGTON, D.C.

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VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
02189					02172									
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>31 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b> d. STREET ADDRESS <b>802 North Wayne St., Apt. 103</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <b>Catherine Mable Williams</b> First Middle Last					<b>4. DATE OF DEATH</b> <b>February 4, 1962</b> Month Day Year									
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>July 23, 1920</b>		<b>9. AGE</b> (In years last birthday) <b>41</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.						
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Office manager</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Civil Service</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Missouri</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>						
<b>13. FATHER'S NAME</b> <b>Finis Williams</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>Emmajoe Payton</b>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)					<b>16. SOCIAL SECURITY NO.</b> <b>577-16-2918</b>					<b>17. INFORMANT</b> <b>The Medical Record</b>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-respiratory failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Septicemia due to E. Coli and renal failure</b> DUE TO (c) <b>Acute Myelogenous Leukemia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>204-3</b> INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>11 days</b> <b>6 months</b>										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					<b>2Db. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>2Dd. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>2De. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>2Df. (City or town)</b> (County) (State)								
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>January 4, 1962</b> to <b>February 4, 1962</b> , that <b>10</b> (we) last saw the deceased alive on <b>February 4, 1962</b> , and that death occurred at <b>9:10 PM</b> , from the causes and on the date stated above.														
<b>22a. SIGNATURE</b> <b>Robert H. Levin</b> M.D.					<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/> <b>February 5, 1962</b> <b>22b. DATE SIGNED</b>									
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Robert H. Levin</b>					<b>22d. ADDRESS</b> <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>									
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial-Transit</b>		<b>23b. DATE THEREOF</b> <b>2/6/62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Fayette Cemetery</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Fayette, Missouri</b>								
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Robert A. Pumphrey, Bethesda, Maryland</b>					<b>25a. REC'D BY REGISTRAR</b> <b>FEB 9 '62</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Evans</b>							





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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02190

## CERTIFICATE OF DEATH

02173

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>23 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u> ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Leonardtwn</u> d. STREET ADDRESS <u>No street address</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <u>Richard Lee Wilson Jr.</u>				<b>4. DATE OF DEATH</b> <u>February 28, 19 62</u>											
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>May 25, 1958</u>									
<b>9. AGE</b> (In years last birthday) <u>3</u> yrs. <table border="1"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Child</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Washington, D.C.</u>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.													
Months	Days	Hours	Min.												
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Richard L. Wilson, Sr.</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Rose Greenwell</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>									
<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> <u>The Medical Records</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>involvement of liver, lymph nodes, and kidneys</u> <u>204.3</u> DUE TO <u>Necrotizing, hemorrhagic bronchopneumonia of</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Right and left lungs</u> DUE TO (c) <u>Ulceration, esophagus</u>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 yrs. 4 mo. 12 hours</u>									
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b>															
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>									
<b>21. I certify that</b> <u>XX</u> (this hospital) attended the deceased from <u>February 5, 19 62</u> to <u>February 28, 19 62</u> that (I) (we) last saw the deceased alive on <u>February 28, 19 62</u> and that death occurred at <u>4:25 p.m.</u> from the causes and on the date stated above.															
<b>22a. SIGNATURE</b> <u>J. David Heywood</u>				<b>22b. DATE SIGNED</b> <u>March 1, 1962</u>											
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>J. David Heywood</u>				<b>22d. ADDRESS</b> <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>											
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>3-3-1962</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>ST ALOYSUIS CEMETERY</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>LEONARDTOWN, MD.</u>									
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W W Chambers Co</u>				<b>25a. REC'D BY REGISTRAR</b> <u>5 '62</u>											
<b>ADDRESS</b> <u>400 Chapin W</u>				<b>25b. REGISTRAR'S SIGNATURE</b> <u>Carlton S. P...</u>											

• **Stylized**

• 1992 1032

Abstract: This paper discusses the role of the state in the development of the private sector in the context of the transition from a centrally planned to a market economy. It argues that the state should play a role in creating a favorable environment for private enterprise, but should not directly control the economy. The paper also discusses the importance of privatization and the role of the state in the process.

Ensemble-Variation

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02191											
Item 9 Film G306 2/9/62 iwk											
02174											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont. Co.</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>25 Silver Spring</u>				d. STREET ADDRESS <u>1935 Bonifant St.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Joseph</u> First <u>Winner</u> Middle <u>Winner</u> Last <u>Winner</u>				4. DATE OF DEATH <u>Feb</u> Month <u>1</u> Day <u>19</u> Year <u>62</u>							
5. SEX <u>male</u>		6. COLOR OF RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY-1879</u>		9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>gold letterer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired-private</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Ukraine</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Winner</u>				14. MOTHER'S MAIDEN NAME <u>Martha Brodsky</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>				17. INFORMANT <u>DR. HARRY J. WINNER</u> Address <u>1819 COLTON RD ADELPHI - MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>45</u> IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>45</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1/17</u> to <u>Feb. 1</u> , 19 <u>62</u> ; that (I) (we) last saw the deceased alive on <u>Feb. 1</u> , 19 <u>62</u> , and that death occurred at <u>11</u> A.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Abraham Danish</u>				22b. DATE SIGNED <u>2-2-62</u>							
22c. PHYSICIAN'S NAME (Type) <u>A Abraham Danish</u>				22d. ADDRESS <u>1106 Spring M. N.J. Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>2-4-62</u>				23c. NAME OF CEMETERY OR CREMATORY <u>BNAI ABRAHAM CEM.</u>			
23d. LOCATION (City, town or county) <u>NEWARK - N.J.</u>				23e. REC'D BY REGISTRAR <u>7</u> '62				23f. REGISTRAR'S SIGNATURE <u>William S. Kane</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>B. Sangansky</u> ADDRESS <u>3501 14th St. W. Wash</u>											

18150

18150



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02192						02175					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			e. STATE			b. COUNTY		
Montgomery			MARYLAND			New York			New York		
c. LENGTH OF STAY IN 1b			d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS		
Bethesda			7 days			New York			355 West 246th Street		
The Clinical Center, Bethesda 14, Md.						69X-3					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
First		Middle		Last		Month		Day		Year	
Harold		George		Wolff		February		21		19 62	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.		IF UNDER 1 MONTH	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		May 26, 1897		64		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Physician				Medicine		New York			U.S.A.		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
Lewis Wolff						Emma Weisslader					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)						17. INFORMANT					
No						The Medical Record					
16. SOCIAL SECURITY NO.						18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
Unascertainable						The Clinical Center, Bethesda 14, Maryland					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						INTERVAL BETWEEN ONSET AND DEATH					
332 X DUE TO						CARDIAC ARREST					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						(b) OCCUSION INTERNAL CAROTID ARTERY LEFT AND MIDDLE CEREBRAL RIGHT					
DUE TO (c)						8 DAYS					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour e.m. p.m. 19				While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>							
21. I certify that (this hospital) attended the deceased from February 14, 1962 to February 21 1962, that (we) last saw the deceased alive on February 21 1962, and that death occurred at 9:58PM from the causes and on the date stated above.											
22a. SIGNATURE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
George Milton Shy								22 Feb 62			
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
George Milton Shy, M.D.						The Clinical Center, National Institutes of Health, Bethesda 14, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Feb 24, 1962				Tenncliff		Westchester, New York					
24 FUNERAL DIRECTOR'S SIGNATURE						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Kaffell						475-H-1 NY 26		FEB 26 62		C. S. Thana	

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New York

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Madison

Madison

Investigation of the Clinical Center, Madison, Wis.

February 11, 1897

1897

February 11, 1897

The Clinical Center, Madison, Wis.

George Wilson, M.D.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02193

02176

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. San. &amp; Hosp.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Wash. D.C.</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>47X-3</u> d. STREET ADDRESS <u>7704 Morningside Dr.</u>								
<b>3. NAME OF DECEASED</b> (Type or print) <u>HING WONG</u>		<b>4. DATE OF DEATH</b> Month <u>2</u> Day <u>12</u> Year <u>1962</u>		<b>e. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
<b>5. SEX</b> <u>MALE</u>	<b>6. COLOR OR RACE</b> <u>YELLOW</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>6-5-89</u>	<b>9. AGE</b> (In years last birthday) <u>72</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>	IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.										
Months	Days	Hours	Min.									
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Waiter</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Restaurant</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>China</u>								
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>AMER.</u>		<b>13. FATHER'S NAME</b> <u>?</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>?</u>								
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>?</u>		<b>17. INFORMANT</b> <u>Hospital Records</u>								
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia bilat.</u> DUE TO (b) <u>Ch. Weg. Myocarditis</u> (c) <u>Anemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>4 days</u> <u>1</u> <u>4 days</u>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>												
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)										
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b>	<b>(County)</b>	<b>(State)</b>							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>2/12/1962</u> , <b>to</b> <u>2/12/1962</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>2/12/1962</u> , <b>and that death occurred at</b> <u>2:00 P.M.</u> , <b>from the causes and on the date stated above.</b>												
<b>22a. SIGNATURE</b> <u>Howard T. Moore</u>		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/>	<b>MED. DIRECTOR</b> <input type="checkbox"/>	<b>STAFF PHYS.</b> <input type="checkbox"/>	<b>22b. DATE SIGNED</b>							
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Howard T. Moore M.D.</u>		<b>22d. ADDRESS</b>										
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE THEREOF</b> <u>2-17-62</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>George Washington Cem</u>	<b>23d. LOCATION</b> (City, town or county) <u>Hyattsville</u>	<b>(State)</b> <u>Md.</u>								
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. W. Loe</u>		<b>ADDRESS</b> <u>300 4th St. N.E.</u>	<b>25a. REC'D BY REGISTRAR</b> <u>DATE FEB 14 '62</u>	<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Thomas</u>								

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George Washington University

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02194					02177				
Item 9 Film G308 3/9/62 mh									
1. PLACE OF DEATH a. COUNTY <b>Montg</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>X Gaithersburg</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>20yrs</b>					d. STREET ADDRESS <b>110 N. Diamond Ave</b>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>Benjamin</b> Middle <b>Owen</b> Last <b>Woodward</b>					4. DATE OF DEATH Month <b>Feb</b> Day <b>27</b> Year <b>19 62</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 31-1871</b>		9. AGE (In years last birthday) <b>90 1/2 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			
13. FATHER'S NAME <b>Roszel Woodward</b>					14. MOTHER'S MAIDEN NAME <b>Eliza J. Reid</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)					16. SOCIAL SECURITY NO.				
17. INFORMANT <b>Corrie V. Woodward. Gaithersburg. Md.</b>					Address <b>110 N. Frederick -Ave</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis.</b> DUE TO (b) <b>Artherosclerotic Heart Disease</b> DUE TO (c) <b>4-20-0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>2/27/62</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>1958</b> to <b>2/27</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>2/17</b> , 19 <b>62</b> , and that death occurred at <b>8:30</b> A.M. from the causes and on the date stated above.									
22a. SIGNATURE <b>Luciano I. Leal</b> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <b>Luciano I. Leal</b>					22d. ADDRESS <b>Gaithersburg, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-2-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak</b>		23d. LOCATION (City, town or county) (State) <b>Gaithersburg Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner. Gaithersburg Md.</b>					ADDRESS		25a. REC'D BY REGISTRAR <b>MAR 6 '62</b>		
							25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>		

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United States Government

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton.</b> c. LENGTH OF STAY IN lb <b>22 days.</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>MONTGOMERY.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>59 BETHESDA</b> d. STREET ADDRESS <b>6216 WOODWOOD RD.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>J. BRUCE</b> First Middle Last <b>WRIGHT</b>		4. DATE OF DEATH Month Day Year <b>FEB. 21 1962.</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 24, 1877</b>
9. AGE (In years last birthday) <b>84 yrs.</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Unknown</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>Yes-Unknown</b>		17. INFORMANT <b>A. Bruce Wright - 6216 Woodwood Rd. Bethesda, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Congestive Heart Failure</b> DUE TO (b) <b>Hypertensive and Coronary Atherosclerotic Heart Disease</b> DUE TO (c) <b>2 years</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Death - 2/21/62</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>Death - 2/21/62</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF DEATH Month, Day, Year Hour a.m. <b>10:30 A.M.</b> p.m. <b>2/21 1962</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 10, 1962</b> to <b>Feb. 21, 1962</b> , that (I) (we) last saw the deceased alive on <b>Feb. 11, 1962</b> , and that death occurred at <b>10:30 A.M.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Frank S. Bacon</b> 22c. PHYSICIAN'S NAME (Type) <b>Frank S. Bacon</b>		22b. DATE SIGNED <b>Feb. 21, 1962</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>1150 Conn. Ave. N. W., Wash. DC</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>2/21/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>	23d. LOCATION (City, town or county) (State) <b>Suitland, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>FEB 23 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

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